ANALYSIS OF MEDICAID HMO

(FY2007 Appropriation Bill - Public Act 330 of 2006)

Within 30 days receipt of final report

Section 1662: (1) The department shall assure that an external quality review of each contracting HMO is performed that results in an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the HMO or its contractors furnish to Medicaid beneficiaries. (2) The department shall provide a copy of the analysis of the Medicaid HMO annual audited health employer data and information set reports and the annual external quality review report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director, within 30 days of the department's receipt of the final reports from the contractors. (3) The department shall work with the Michigan association of health plans and the Michigan association for local public health to improve service delivery and coordination in the MSS/ISS and EPSDT programs. (4) The department shall assure that training and technical assistance are available for EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor

Janet Olszewski, Director

State of Michigan

Department of Community Health

2005–2006 External Quality Review Technical Report

for

Medicaid Health Plans

March 2007

HSAG Health Services Advisory Group

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HSAG HEALTH SERVICES ADVISORY GROUP

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ACKNOWLEDGMENTS AND COPYRIGHTS

Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations, called Medicaid Health Plans (MHPs) in Michigan. The report of results must also contain an assessment of the strengths and weaknesses of the plans with regard to health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MHPs. In an effort to meet this requirement, the State of Michigan Department of Community Health (MDCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare the annual technical report.

The State of Michigan contracts with the following MHPs represented in this report:

- **Cape Health Plan** (**CAP**)
- **Community Choice Michigan** (**CCM**)
- **Great Lakes Health Plan** (**GLH**)
- **Health Plan of Michigan, Inc.** (**HPM**)
- **HealthPlus Partners, Inc.** (**HPP**)
- **M-CAID** (**MCD**)
- **McLaren Health Plan** (**MCL**)
- **Midwest Health Plan** (**MID**)
- **Molina Healthcare of Michigan** (**MOL**)
- **OmniCare Health Plan** (**OCH**)
- **Physicians Health Plan of Mid-Michigan Family Care** (**PMD**)
- **Physicians Health Plan of Southwest Michigan** (**PSW**)
- **Priority Health Government Programs, Inc**. (**PRI**)
- **Total Health Care, Inc.** (**THC**)
- **Upper Peninsula Health Plan** (**UPP**)

Scope of External Quality Review (EQR) Activities Conducted

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as listed below:

- **Compliance Monitoring**: Evaluation of the compliance of the 15 MHPs with federal Medicaid managed care regulations was performed by MDCH using an on-site review process. HSAG examined, compiled, and analyzed the on-site review results, corrective action plans, and annual quality improvement (QI) evaluation/effectiveness reports.
- **Validation of Performance Measures**: Each MHP underwent a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- **Validation of Performance Improvement Projects (PIPs)**: HSAG reviewed one PIP for each MHP to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care to be achieved and giving confidence in the reported improvements.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**: MDCH required the administration of the CAHPS 3.0H Adult Medicaid Survey in 2005. Eligible adult members from each MHP who met the enrollment and age criteria during the calendar year completed the survey.

Summary of Findings

The following is a statewide summary of the conclusions drawn regarding the MHPs' general performance on the four activities.

Compliance Review

Overall, the annual compliance review demonstrated strengths for the MHPs, with appropriate knowledge of processes and documentation of policies and procedures. The statewide average for annual compliance reviews was 89.0 percent. For the six individual standards within the annual compliance review, two statewide averages were above 90.0 percent and the other four were above 80.0 percent. The Administrative and Member standards had 14 out of 15 MHPs score 100 percent, and at least one MHP scored 100 percent for each of the six standards within the annual compliance review.

Table 1-1—Summary of Data From the 2004–2005 Review of Compliance Review Standards

Standards	Range of Scores	Statewide Average
Standard 1: Administrative	33%–100%	97.0%
Standard 2: Provider	50%–100%	88.5%
Standard 3: Member	25%–100%	93.9%
Standard 4: Quality Assurance/Utilization Review	60%–100%	82.8%
Standard 5: MIS/Data Reporting/Claims Processing	40%–100%	85.5%
Standard 6: Fraud and Abuse	64%–100%	86.1%

Validation of Performance Measures

All of the MHPs demonstrated the capability to calculate and report accurate performance measures specified by the State. The statewide averages for 6 of the 33 performance measures were above the national Medicaid HEDIS 2004 75th percentile, while the rates for 27 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. The rates improved for 30 of the 33 performance measures (90.9 percent) compared with rates reported in 2004. None of the statewide averages was below the national Medicaid HEDIS 2004 25th percentile, further evidence that performance measures, in general, were a relative statewide strength.

Table 1-2—Overall Statewide Average Scores for Performance Measures

Performance Measures	2004 MI Medicaid	2005 MI Medicaid	Performance Level for 2005
Childhood Immunization Combo 2	67.4%	72.7%	★★★
Adolescent Immunization Combo 2	34.5%	54.7%	★★★
Appropriate Treatment for Children With URI	75.0%	76.5%	★★
Breast Cancer Screening	54.6%	54.7%	★★
Cervical Cancer Screening	62.6%	65.5%	★★
Controlling High Blood Pressure	53.9%	60.4%	★★
Chlamydia Screening 16 to 20 Years	48.2%	47.6%	★★
Chlamydia Screening 21 to 26 Years	53.8%	53.1%	★★
Chlamydia Screening (Combined)	50.9%	50.8%	★★
Diabetes Care—HbA1c Testing	74.0%	81.2%	★★
Diabetes Care—Poor HbA1c Control*	51.2%	41.4%	★★
Diabetes Care—Eye Exam	42.3%	50.0%	★★
Diabetes Care—LDL-C Screen	74.6%	83.3%	★★
Diabetes Care—LDL-C Level <130	48.6%	58.0%	★★★
Diabetes Care—LDL-C Level <100	29.1%	37.3%	★★★
Diabetes Care—Nephropathy	40.7%	50.1%	★★
Asthma 5 to 9 Years	61.0%	65.1%	★★
Asthma 10 to 17 Years	62.5%	64.2%	★★
Asthma 18 to 56 Years	69.5%	71.8%	★★★
Asthma Combined Rate	65.5%	69.4%	★★★
Medical Assistance With Smoking Cessation	66.7%	68.5%	★★
Well-Child 1st 15 Months, 0 Visits*	4.2%	3.4%	★★
Well-Child 1st 15 Months, 6+ Visits	36.8%	43.5%	★★
Well-Child 3rd–6th Years of Life	55.3%	58.3%	★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 1-2—Overall Statewide Average Scores for Performance Measures			
Performance Measures	2004 MI Medicaid	2005 MI Medicaid	Performance Level for 2005
Adolescent Well-Care Visits	34.2%	38.5%	★★
Timeliness of Prenatal Care	71.5%	79.2%	★★
Postpartum Care	44.9%	54.8%	★★
Children's Access 12–24 Months	91.5%	92.5%	★★
Children's Access 25 Months–6 Years	78.0%	78.8%	★★
Children's Access 7–11 Years	76.7%	78.9%	★★
Adolescents' Access 12–19 Years	74.7%	78.1%	★★
Adults' Access 20–44 Years	75.0%	77.6%	★★
Adults' Access 45–64 Years	82.6%	84.7%	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Performance Improvement Projects (PIPs)

In general, the highest rates across all activities were for PIPs. All MHPs received a validation status of *Met* or *Partially Met* for the Blood Lead Testing PIP, demonstrating the capability to measure performance and implement and evaluate systematic interventions. The MHPs were at various stages of demonstrating the effectiveness of interventions, as well as demonstrating sustained improvement. Overall, however, performance was considered above average for conducting PIPs.

Table 1-3—Summary of Data From the Validation of 2005–2006 Blood Lead Testing PIPs		
Validation Activity	Number of PIPs Meeting all Evaluation Elements/Number Reviewed	Number of PIPs Meeting all Critical Elements/Number Reviewed
Activity I—Appropriate Study Topic	15/15	15/15
Activity II—Clearly Defined, Answerable Study Question	15/15	15/15
Activity III—Clearly Defined Study Indicator	13/15	13/15
Activity IV—Correctly Identified Study Population	15/15	15/15
Activity V—Valid Sampling Techniques	15/15	15/15
Activity VI—Accurate/Complete Data Collection	10/15	NA for all MHPs
Activity VII—Appropriate Improvement Strategies	14/14	14/14
Activity VIII—Sufficient Data Analysis and Interpretation	8/14	14/14
Activity IX—Real Improvement Achieved	8/14	No Critical Elements
Activity X—Sustained Improvement	4/7	No Critical Elements

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS evaluation (Table 1-4 and Table 1-5) showed generally improving, but still about average, performance from a national perspective. Members generally believed they could get needed care, but often it took too long to get the services. Overall, Customer Service was the only one of the measures to average above the national 75th percentile, demonstrating a relative statewide strength. No measure averaged below the national 25th percentile. Compared to 2004, all of the rates showed some improvement. However, all of the CAHPS measures offer additional opportunity for improvement with member satisfaction.

Table 1-4—Detailed State Average Results for CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	67.6%	71.3%	2.53	2.59	★★
Getting Care Quickly	43.6%	45.2%	2.15	2.18	★★
How Well Doctors Communicate	57.7%	59.4%	2.42	2.45	★★
Courteous and Helpful Office Staff	63.7%	66.0%	2.50	2.54	★★
Customer Service	62.9%	69.0%	2.51	2.60	★★★

Note: Top Box denotes percentage who responded "Always" or "Not a Problem"

★ = Below average performance (<25th percentile) relative to national Medicaid results

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results

★★★ = Above average performance (≥ 75th percentile) relative to national Medicaid results

Table 1-5—Detailed State Average Scores for CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	55.7%	57.8%	2.39	2.43	★★
Rating of Specialist	58.7%	59.4%	2.42	2.43	★★
Rating of All Health Care	49.1%	52.6%	2.28	2.33	★★
Rating of Health Plan	42.9%	49.9%	2.15	2.28	★★

Note: Top satisfaction denotes the percentage of respondents rating 9 or 10 on a scale of 0 to 10.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Quality, Timeliness, and Access

The assessment of the Quality, Timeliness, and Access domains showed the highest rates were for PIPs, followed by the annual compliance reviews. Both of these areas tended to focus on documentation of processes and should be regarded as MHP strengths. Although the performance measures showed average performance (i.e., between the national 25th and 75th percentiles), in general, these measures also offer the most opportunity for improvement. Improving rates for the performance measures may also improve member satisfaction.

There was little variation in the rates achieved by individual MHPs across the averages within the quality, access, and timeliness domains. This level of consistency suggests that a statewide collaborative project would likely be effective in moving all of the MHPs to higher performance levels. Table 1-6 shows HSAG's assignment of the compliance review standards, performance measures, PIPs, and CAHPS into the domains of Quality, Timeliness, and Access.

Table 1-6—Assignment of Activities to Performance Domains

Compliance Review Standards	Quality	Timeliness	Access
Standard 1. Administrative	✓		
Standard 2. Provider	✓	✓	✓
Standard 3. Member	✓	✓	✓
Standard 4. Quality Assurance/Utilization Review	✓		✓
Standard 5. MIS/Data Reporting/Claims Processing	✓	✓	
Standard 6. Fraud and Abuse	✓	✓	✓
Performance Measures	**Quality**	**Timeliness**	**Access**
1. Childhood Immunization Status	✓	✓	
2. Adolescent Immunization Status	✓	✓	
3. Appropriate Treatment for Children with Upper Respiratory Infection	✓		
4. Breast Cancer Screening	✓		
5. Cervical Cancer Screening	✓		
6. Controlling High Blood Pressure	✓		
7. Chlamydia Screening in Women	✓		
8. Comprehensive Diabetes Care	✓		
9. Use of Appropriate Medications for People With Asthma	✓		
10. Medical Assistance With Smoking Cessation	✓		
11. Adults' Access to Preventive/Ambulatory Health Services			✓
12. Children's and Adolescents' Access to Primary Care Practitioners			✓
13. Prenatal and Postpartum Care		✓	✓
14. Well-Child Visits in the First 15 Months of Life	✓		
15. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
16. Adolescent Well-Care Visits	✓		

Table 1-6—Assignment of Activities to Performance Domains			
PIP Topic	**Quality**	**Timeliness**	**Access**
Blood Lead Testing (Statewide PIP topic for all 15 MHPs)	✓	✓	
CAHPS Topics	**Quality**	**Timeliness**	**Access**
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
Customer Service	✓		
Courteous and Helpful Office Staff	✓		
How Well Doctors Communicate	✓		
Rating of Health Plan	✓		
Rating of Personal Doctor	✓		
Rating of Specialist	✓		
Rating of Health Care	✓		

For MHP-specific strengths, weaknesses, and recommendations, refer to Appendices A–O of this report. For overall State findings see Section 3.

2. External Quality Review Activities

Introduction

This section of the report describes the manner in which data from the activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed.

Compliance Monitoring

Objectives

According to 42 CFR 438.358, the State or its EQRO must conduct a review within a three-year period to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In order to meet this requirement, MDCH performed on-site reviews of its MHPs.

The objectives of the evaluation of the contractual compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines.

Technical Methods of Data Collection

MDCH was responsible for the activities that assessed MHP compliance with federal Medicaid managed care regulations. The Site Visit Survey Tool used to conduct these evaluations is reviewed annually by MDCH and updated as necessary to incorporate contract changes, and to clarify and consolidate criteria. This report reflects activities from the eighth cycle of on-site visits that included all 15 MHPs and took place from October 1, 2004, through September 30, 2005. Review criteria used by MDCH during the on-site visit included the following six core areas:

1. Administrative: Review of items related to the structure of the organization, and composition, function, and activities of the governing body.
2. Provider: Review of subcontracted and delegated functions, provisions for the scope of covered service, primary care providers, network adequacy, and provider relations.
3. Member: Review of content and distribution of member materials, and processes for handling grievances, appeals, and State fair hearing requests.
4. Quality Assurance/Utilization Review: Addressed practice guidelines, the MHP quality assessment and performance improvement (QAPI) program, access to care, the utilization management program, credentialing/recredentialing protocols, and programs for individuals with special health care needs.

5. MIS/Data Reporting/Claims Processing: Examined information system requirements, financial administrative reporting to MDCH, timeliness of payments, and management of enrollment data.
6. Fraud and Abuse: Evaluated fraud and abuse policies and procedures, risk management methodology, claims auditing processes and utilization trending procedures.

Description of Data Obtained

To assess the MHPs' compliance with federal and State requirements, MDCH obtained information from a wide range of written documents produced by the MHPs, including:

- Policies and procedures
- Current QAPI program
- Minutes of meetings of the governing body, quality improvement (QI) committee, compliance committee, utilization management (UM) committee, credentialing committee, and peer review committee
- QI work plan, utilization reports, provider and member profiling reports, QI effectiveness report
- Internal auditing/monitoring plan, auditing/monitoring findings
- Claims review reports, prior authorization reports, complaint log, grievance log, telephone contact log, disenrollment log, MDCH hearing requests, medical record review reports
- Provider service and delegation agreements and contracts
- Provider files, disclosure statements, current sanctioned/suspended provider list
- Organizational chart
- Fraud and abuse log, fraud and abuse reports
- Employee handbook, fliers, employee newsletters, provider manuals, provider newsletters, Web site, educational/training materials, and sign-in sheets
- Member materials including welcome letter, member handbook, member newsletters, provider directory, and certificate of coverage
- Provider manual

For each of the 15 MHPs, MDCH prepared site visit reports that contained narrative findings and corrective actions. These findings served as a factual, comprehensive description of evidence used to support the score for each standard.

HSAG examined, compiled, and analyzed the review results as contained in the 15 MHP site visit reports submitted by MDCH. HSAG also evaluated MHP annual QI evaluation/effectiveness reports that addressed the previous year and a work plan that addressed QI initiatives and projects for the upcoming year. As the QI evaluation documents generally covered an earlier time period than the site visit reports, the MHP could not always address the issues identified during the MDCH on-site visit. HSAG's evaluation of the MHPs' QI evaluation documents addressed global findings and recommendations.

Data Aggregation, Analysis, and How Conclusions Were Drawn

Many of the 55 standards in the tool had substandards or elements that, for the most part, were incorporated into a single score. For each standard reviewed, MHPs received a score based on the following:

- *Pass*, indicating compliance with all elements.
- *Fail*, reflecting lack of compliance with all or critical elements of the standard.
- *Incomplete*, denoting compliance with some, but not all, elements of the standard.
- *Not Reviewed*, indicating that the criterion was reviewed with a passing score at the previous visit, and a letter of attestation was received by MDCH from the plan indicating that there was no change of status.
- *Deemed Status*, showing that the review was deemed compliant based on compliance with the same or similar Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or NCQA accreditation standard.

Scores denoted as *Pass* indicated compliance. Scores of *Fail* and *Incomplete* were not counted toward compliance. HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

In addition to the score, narrative findings from the on-site visit were provided. These findings served as a factual, comprehensive description of evidence used to support the score for each standard. The narrative included specific policy citations, data tables, and dated document references.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the MHPs using findings from the initial and follow-up reviews, the standards were categorized to evaluate each of these three domains. HSAG recognizes the interdependence of Quality, Timeliness, and Access, and has assigned each of the standards and record reviews to one or more of the three domains. The BBA, at 42 CFR 438.204(d) and (g) and at 438.320, provides a framework for using findings from EQR activities to evaluate Quality, Timeliness, and Access. Using this framework, Table 2-1 shows HSAG's assignment of standards to the three domains of performance.

Table 2-1—Assignment of Standards to Performance Domains

Standards	Quality	Timeliness	Access
Standard 1. Administrative	✓		
Standard 2. Provider	✓	✓	✓
Standard 3. Member	✓	✓	✓
Standard 4. Quality Assurance/Utilization Review	✓		✓
Standard 5. MIS/Data Reporting/Claims Processing	✓	✓	
Standard 6. Fraud and Abuse	✓	✓	✓

Validation of Performance Measures

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess each MHP's support systems available to report accurate HEDIS measures.

Technical Methods of Data Collection and Analysis

MDCH required each MHP to collect and report all Medicaid HEDIS measures. Developed and maintained by the NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. MDCH identified the calendar year 2004 (reporting year 2005) as the measurement period for validation.

Each MHP underwent an NCQA HEDIS Compliance Audit™ conducted by an NCQA-licensed audit organization. The audit process was performed according to NCQA protocol. The validation team consisted of two individuals selected for their various skill sets, including statistics, analysis, managed care operations, performance measure reporting, information systems assessments, and computer programming capabilities. The HEDIS Compliance Audit was conducted in compliance with NCQA's *2005 HEDIS Compliance Audit: Standards, Policies, and Procedures,* Volume 5. NCQA's HEDIS Compliance Audit is consistent with the CMS protocols for validation of performance measures.

To complete the validation of performance measures process according to the CMS protocols, HSAG performed an independent evaluation of the audit results and findings in order to determine the validity of each performance measure. The HEDIS Compliance Audits, conducted by the licensed audit organizations, included:

Pre-review Activities: Each MHP was required to complete the NCQA Baseline Assessment Tool (BAT), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix Z of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. The audit team conducted a thorough review of the BAT and supportive documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

On- Site Review: The on-site reviews, which typically lasted two days, included:

- An evaluation of system compliance focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.

- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of the performance measure reporting.
- A closing conference at which the audit team summarized preliminary findings and recommendations.

Post-On-site Review Activities: For each performance measure calculated and reported by the MHPs, the audit team aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on a +/- 5 percent allowable bias. The audit team assigned each measure a designation of *Report* (meaning the measure was determined to be valid and below the allowable threshold for bias), or *Not Report* (meaning the measure was determined to be significantly biased by greater than +/- 5 percent).

Description of Data Obtained

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 2-2 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table 2-2—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
HEDIS Compliance Audit Reports were obtained for each MHP, which included a description of the audit process, the results of the information systems findings, and the final audit designations for each performance measure.	CY 2004 (HEDIS 2005)
Performance Measure Reports, submitted by the MHPs using NCQA's Data Submission Tool, were analyzed and subsequently validated by the HSAG validation team.	CY 2004 (HEDIS 2005)
Previous Performance Measure Reports were reviewed to assess trending patterns and rate for reasonability.	CY 2003 (HEDIS 2004)

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed audit organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDCH-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA DST.
- A final Audit Opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the MHPs using findings from the validation of performance measures, each measure was categorized to evaluate each of the three domains. HSAG recognizes the interdependence of Quality, Timeliness, and Access, and has assigned each of the performance measures to one or more of the three domains. The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate Quality, Timeliness, and Access. Using this framework, Table 2-3 shows HSAG's assignment of performance measures to these domains of performance.

Table 2-3—Assignment of Performance Measures to Performance Domains

Performance Measures	Quality	Timeliness	Access
1. Childhood Immunization Status	✓	✓	
2. Adolescent Immunization Status	✓	✓	
3. Appropriate Treatment for Children with Upper Respiratory Infection	✓		
4. Breast Cancer Screening	✓		
5. Cervical Cancer Screening	✓		
6. Controlling High Blood Pressure	✓		
7. Chlamydia Screening in Women	✓		
8. Comprehensive Diabetes Care	✓		
9. Use of Appropriate Medications for People With Asthma	✓		
10. Medical Assistance With Smoking Cessation	✓		
11. Adults' Access to Preventive/Ambulatory Health Services			✓
12. Children's and Adolescents' Access to Primary Care Practitioners			✓
13. Prenatal and Postpartum Care		✓	✓
14. Well-Child Visits in the First 15 Months of Life	✓		
15. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
16. Adolescent Well-Care Visits	✓		

Validation of Performance Improvement Projects (PIPs)

Objectives

As part of its quality assessment and performance improvement program, each MHP is required by MDCH to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs is to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time in both clinical care and nonclinical areas. This structured method of assessing and improving MHP processes is expected to have a favorable effect on health outcomes and consumer satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State is required to validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this validation requirement for the MHPs, MDCH contracted with HSAG.

The primary objective of PIP validation was to determine each MHP's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The MDCH mandated that each MHP conduct a Blood Lead Testing PIP in 2005-2006. The MDCH mandated the parameters of the PIP, and HSAG performed validation activities for each plan's PIP.

Technical Methods of Data Collection and Analysis

The HSAG validation team consisted, at a minimum, of an analyst with expertise in statistics and study design, and a reviewer with expertise in performance improvement processes. The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication *Validating Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002* (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with MDCH, developed the PIP Summary Form. This form was completed by each MHP and submitted to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and assured that all CMS protocol requirements were addressed.

With MDCH input and approval, HSAG developed a PIP validation tool to ensure uniform assessment of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS protocol activities:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question
- Activity III. Clearly Defined Study Indicator(s)
- Activity IV. Correctly Identified Study Population
- Activity V. Valid Sampling Techniques (if sampling was used)
- Activity VI. Accurate/Complete Data Collection

- Activity VII. Appropriate Improvement Strategies
- Activity VIII. Sufficient Data Analysis and Interpretation
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

Description of Data Obtained

The data needed to conduct the PIP validations were obtained from the MHPs' PIP Summary Form. This form provided detailed information about each MHP's PIP as it related to the 10 activities being reviewed and evaluated for fiscal year (FY) 2005–2006.

Data Aggregation, Analysis, and How Conclusions Were Drawn

Each of the 10 protocol activities consisted of elements necessary for the successful completion of a valid PIP. The elements within each activity were scored by the HSAG review team as *Met*, *Partially Met*, *Not Met*, or *Not Applicable* (*NA*). To assure a valid and reliable review, some of the elements were designated "critical" elements by HSAG. These were elements that HSAG determined had to be *Met* in order for the MHP to produce an accurate and reliable PIP. Given the importance of critical elements to this scoring methodology, any critical element that received a *Not Met* status resulted in an overall validation rating for the PIP of *Not Met* and required future revisions and resubmission of the PIP to HSAG. An MHP would be given a *Partially Met* score if 60 percent to 79 percent of all elements were *Met* across all activities, or one or more critical elements were *Partially Met.* The MHPs had an opportunity to resubmit revised PIP Summary Forms and additional information in response to any *Partially Met* or *Not Met* evaluation scores, regardless of whether the evaluation element was critical or noncritical. The resubmitted documents were evaluated and the PIPs rescored, if applicable.

HSAG followed the above methodology for validating the PIPs for all 15 MHPs in order to assess the degree to which the projects were designed, conducted, and reported in a methodologically sound manner.

After completing the validation review, HSAG prepared a report of the findings and recommendations for each validated PIP. These reports, which complied with 42 CFR 438.364, were forwarded to MDCH and the appropriate MHP.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the MHPs using findings from the validation of PIPs, each PIP was categorized to evaluate each of these three domains. HSAG recognizes the interdependence of Quality, Timeliness, and Access, and has assigned each of the PIPs to one or more of the three domains. The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate Quality, Timeliness, and Access. The Blood Lead Testing PIP was assigned to Quality and Timeliness.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey looks at key satisfaction drivers throughout the continuum of care, including health plan performance and the member's experience in the physician's office.

Objectives

The objective of the CAHPS survey is to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through the administration of the Adult CAHPS 3.0H Survey. The survey encompasses a set of standardized items (67 items) that assess patient perspectives on care. To achieve reliability and validity of findings, HEDIS sampling and data collection procedures were followed for the selection of members and the distribution of surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from the multiple waves of mailings and response-gathering activities were aggregated into a database for analysis.

The survey questions were categorized by nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and with all health care. The composite scores were derived from sets of questions put in the following groups to address different aspects of care: getting needed care, getting care quickly, how well doctors communicate, courteous and helpful office staff, and customer service. When a minimum of 100 responses for an item were not received, the results of the measure were not applicable for reporting, resulting in a Not Applicable (NA) designation.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction rating (response value of 8, 9, or 10 on a scale of 0 to 10) was calculated. This was referred to as a question summary rate. In addition, a three-point rating mean was calculated. Response values of 0 through 6 were given a score of 1; 7 and 8 a score of 2; and 9 and 10 a score of 3. The three-point rating mean was the sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS questions used in composites were scaled in one of two ways:

- Never/Sometimes/Usually/Always
- Big Problem/Small Problem/Not a Problem

NCQA defined a top box response for these composites as a response of Always or Not a Problem.

A positive response for these composites was defined as a response of Usually and Always, or Not a Problem. This was referred to as a global proportion for the composite scores.

In addition, a three-point composite mean was calculated for each of the composite scores. Scoring was based on a three-point scale. Responses of Always and Not a Problem were given a score of 3, responses of Usually or Small Problem were given a score of 2, and Never/Sometimes/Big Problem responses were given a score of 1. The three-point composite mean was the average of the mean score for each question included in the composite.

Details on the global ratings, composite scores, and national benchmarks are included in the separate CAHPS reports prepared for each MHP by vendors.

Description of Data Obtained

The Adult Medicaid CAHPS Survey was used to obtain member satisfaction data for members meeting enrollment criteria during the 2005 measurement year.

Data Aggregation, Analysis, and How Conclusions Were Drawn

The CAHPS questions were summarized by nine measures of satisfaction. These measures were calculated as described above and assigned to the domains of Quality, Timeliness, and Access as shown in Table 2-4.

Table 2-4—CAHPS Assignment to Performance Domains

Topics	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
Customer Service	✓		
Courteous and Helpful Office Staff	✓		
How Well Doctors Communicate	✓		
Rating of Health Plan	✓		
Rating of Personal Doctor	✓		
Rating of Specialist	✓		
Rating of Health Care	✓		

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table 3-1 shows each of the six compliance review standards, the range of scores across the 15 MHPs, and the statewide averages for each of the standards.

Table 3-1—Summary of Data From the 2004–2005 Review of Compliance Review Standards

Standards	Range of Scores	Statewide Average
Standard 1: Administrative	33%–100%	97.0%
Standard 2: Provider	50%–100%	88.5%
Standard 3: Member	25%–100%	93.9%
Standard 4: Quality Assurance/Utilization Review	60%–100%	82.8%
Standard 5: MIS/Data Reporting/Claims Processing	40%–100%	85.5%
Standard 6: Fraud and Abuse	64%–100%	86.1%

Table 3-1 shows that all statewide averages were above 80.0 percent and two were above 90.0 percent. At least one MHP scored 100 percent for each of the six standards within the annual compliance review. After accounting for the strengths seen in categories with statewide averages exceeding 90.0 percent, the remaining four categories were only separated by 5.7 percentage points. These four categories, from highest to lowest statewide average, were Provider, Fraud and Abuse, Management Information System (MIS)/Data Reporting/Claims Processing, and Quality Assurance/Utilization Review. Overall, the annual compliance reviews documented the MHPs' strengths in having appropriate knowledge of processes and documentation of policies and procedures.

Table 3-2—Distribution of Perfect Scores From the 2004–2005 Review of Standards

Standards	Number of MHPs Passing All Elements	Percentage of MHPs Passing All Elements
Standard 1: Administrative	14	93.3%
Standard 2: Provider	7	46.7%
Standard 3: Member	14	93.3%
Standard 4: Quality Assurance/Utilization Review	2	13.3%
Standard 5: MIS/Data Reporting/Claims Processing	10	66.7%
Standard 6: Fraud and Abuse	3	20.0%

Table 3-2 provides the distribution of MHPs scoring 100 percent for each of the categories in the review. Both the Administrative and Member categories had 14 out of 15 MHPs score 100 percent. On the other end of the spectrum, Quality Assurance/Utilization Review had two MHPs score 100 percent and Fraud and Abuse had three perfect scores. From this perspective, Quality Assurance/Utilization Review and Fraud and Abuse form the highest overarching priorities statewide for improving performance on the annual compliance reviews, followed by the elements within the Provider standard that were generally not passed. The majority of MHPs scored 100 percent on each of the other categories.

The data used to create these tables, especially Table 3-1, also presented the following findings from an overall evaluation of the results: the lowest score in four of the six categories (i.e., Administrative, Member, Quality Assurance/Utilization Review, and Fraud and Abuse) was posted by **THC**. **MOL**'s score for the Provider category was the lowest among the MHPs, and **UPP**'s score was the lowest for MIS/Data Reporting/Claims Processing.

Through its reviews and follow-up to plans of correction, the State met the objective to provide information about the MHPs' compliance and noncompliance with Medicaid managed care regulations. Although the range of scores appeared to vary greatly, most of the low scores were from one MHP. Areas of noncompliance were minimal, and corrective actions have been noted, when applicable.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to: evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures was performed, as well as a measure-specific review of all reported measures.

The results from the validation of performance measures activity are shown in Table 3-3. For each performance measure, the table shows the percentage and number of MHPs that were assigned a validation status of *Report* (indicating the performance measure was determined to be valid).

Table 3-3—Summary of Data from Validation of HEDIS 2005 Performance Measures: Percentage and Number of MHPs Achieving Each Validation Status by Measure

Performance Measures	Report Status	
	Percentage of MHPs	Number of MHPs
1. Childhood Immunization Status	100%	15
2. Adolescent Immunization Status	100%	15
3. Appropriate Treatment for Children with Upper Respiratory Infection	100%	15
4. Breast Cancer Screening	100%	15
5. Cervical Cancer Screening	100%	15
6. Controlling High Blood Pressure	100%	15
7. Chlamydia Screening in Women	100%	15
8. Comprehensive Diabetes Care	100%	15
9. Use of Appropriate Medications for People With Asthma	100%	15
10. Medical Assistance With Smoking Cessation	100%	15
11. Adults' Access to Preventive/Ambulatory Health Services	100%	15
12. Children's and Adolescents' Access to Primary Care Practitioners	100%	15
13. Prenatal and Postpartum Care	100%	15
14. Well-Child Visits in the First 15 Months of Life	100%	15
15. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	100%	15
16. Adolescent Well-Care Visits	100%	15

The performance data were collected accurately from a wide variety of sources. All of the MHPs demonstrated the capability to calculate and report accurate performance measures that complied with HEDIS specifications. No MHP received a status of *Not Report* (indicating that the performance measure was determined to be not valid).

Table 3-4 on the next page shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table 3-4—Overall Statewide Average Scores for Performance Measures			
Performance Measures	2004 MI Medicaid	2005 MI Medicaid	Performance Level for 2005
Childhood Immunization Combo 2	67.4%	72.7%	★★★
Adolescent Immunization Combo 2	34.5%	54.7%	★★★
Appropriate Treatment for Children With URI	75.0%	76.5%	★★
Breast Cancer Screening	54.6%	54.7%	★★
Cervical Cancer Screening	62.6%	65.5%	★★
Controlling High Blood Pressure	53.9%	60.4%	★★
Chlamydia Screening 16 to 20 Years	48.2%	47.6%	★★
Chlamydia Screening 21 to 26 Years	53.8%	53.1%	★★
Chlamydia Screening (Combined)	50.9%	50.8%	★★
Diabetes Care—HbA1c Testing	74.0%	81.2%	★★
Diabetes Care—Poor HbA1c Control*	51.2%	41.4%	★★
Diabetes Care—Eye Exam	42.3%	50.0%	★★
Diabetes Care—LDL-C Screen	74.6%	83.3%	★★
Diabetes Care—LDL-C Level <130	48.6%	58.0%	★★★
Diabetes Care—LDL-C Level <100	29.1%	37.3%	★★★
Diabetes Care—Nephropathy	40.7%	50.1%	★★
Asthma 5 to 9 Years	61.0%	65.1%	★★
Asthma 10 to 17 Years	62.5%	64.2%	★★
Asthma 18 to 56 Years	69.5%	71.8%	★★★
Asthma Combined Rate	65.5%	69.4%	★★★
Medical Assistance With Smoking Cessation	66.7%	68.5%	★★
Well-Child 1st 15 Months, 0 Visits*	4.2%	3.4%	★★
Well-Child 1st 15 Months, 6+ Visits	36.8%	43.5%	★★
Well-Child 3rd–6th Years of Life	55.3%	58.3%	★★
Adolescent Well-Care Visits	34.2%	38.5%	★★
Timeliness of Prenatal Care	71.5%	79.2%	★★
Postpartum Care	44.9%	54.8%	★★
Children's Access 12–24 Months	91.5%	92.5%	★★
Children's Access 25 Months–6 Years	78.0%	78.8%	★★
Children's Access 7–11 Years	76.7%	78.9%	★★
Adolescents' Access 12–19 Years	74.7%	78.1%	★★
Adults' Access 20–44 Years	75.0%	77.6%	★★
Adults' Access 45–64 Years	82.6%	84.7%	★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 3-4 shows the average statewide rate was above the national Medicaid HEDIS 2004 75th percentile for 6 of the 33 performance measures. These measures included both the Childhood and Adolescent Immunization Combo 2, both LDL-C outcome measures (i.e., Level <130, and Level <100), and the Asthma 18 to 56 Years and Combined rates. Statewide, these measures represent areas of strength across the MHPs.

The table also shows that rates for 27 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. None of the rates were below the national Medicaid HEDIS 2004 25th percentile, providing further evidence that performance measures, in general, were an area of relative strength for the MHPs statewide.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. The rates reported in 2005 improved for 30 of the 33 performance measures (90.9 percent) over the rates reported in 2004. It should be noted that the rate for Adolescent Immunization Combo 2 increased from 34.5 percent to 54.7 percent between the 2004 and 2005 assessments, indicating a substantive improvement of 20.2 percentage points statewide over the single year.

The rates declined for all three of the Chlamydia screening measures compared to 2004. These measures represent opportunities for improvement statewide. Nonetheless, other important opportunities for improvement statewide could exist that are hidden by the averages presented and assessed in Table 3-4. For this reason, Table 3-5 includes the number of MHPs with rates for performance measures below average, average, and above average for 2005.

Table 3-5—Distribution of MHP Performance Compared to National Medicaid Benchmarks

Performance Measures	Number of Stars		
	★	★★	★★★
Childhood Immunization Combo 2	0	2	13
Adolescent Immunization Combo 2	0	1	14
Appropriate Treatment for Children With URI	4	9	2
Breast Cancer Screening	5	9	1
Cervical Cancer Screening	1	11	3
Controlling High Blood Pressure	3	8	4
Chlamydia Screening 16 to 20 Years	1	10	4
Chlamydia Screening 21 to 26 Years	0	10	5
Chlamydia Screening (Combined)	1	9	5
Diabetes Care—HbA1c Testing	1	8	6
Diabetes Care—Poor HbA1c Control*	1	8	6
Diabetes Care—Eye Exam	1	8	6
Diabetes Care—LDL-C Screen	0	6	9

* Adjusted for the reversed structure of this indicator.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 3-5—Distribution of MHP Performance Compared to National Medicaid Benchmarks			
Performance Measures	Number of Stars		
	★	★★	★★★
Diabetes Care—LDL-C Level <130	0	8	7
Diabetes Care—LDL-C Level <100	0	6	9
Diabetes Care—Nephropathy	0	10	5
Asthma 5 to 9 Years	3	5	7
Asthma 10 to 17 Years	3	5	7
Asthma 18 to 56 Years	0	7	8
Asthma Combined Rate	1	7	7
Medical Assistance With Smoking Cessation	0	8	7
Well-Child 1st 15 Months, 0 Visits*	5	8	2
Well-Child 1st 15 Months, 6+ Visits	3	11	1
Well-Child 3rd–6th Years of Life	2	13	0
Adolescent Well-Care Visits	0	12	3
Timeliness of Prenatal Care	3	7	5
Postpartum Care	4	10	1
Children's Access 12–24 Months	3	9	3
Children's Access 25 Months–6 Years	5	10	0
Children's Access 7–11 Years	5	10	0
Adolescents' Access 12–19 Years	3	12	0
Adults' Access 20–44 Years	1	12	2
Adults' Access 45–64 Years	3	6	6

* Adjusted for the reversed structure of this indicator.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that five of the MHPs were below the 25th national percentile for four performance measures. The measures are: Breast Cancer Screening; Well-Child 1st 15 Months, 0 Visits; and Children's Access (25 Months–6 Years and 7-11 Years). These measures, therefore, are recommended as high-priority opportunities for improvement statewide.

Both Immunization Combo 2 measures (i.e., for children and for adolescents), however, are recognized as strengths statewide, with rates for nearly all of the MHPs being above the 75th national percentile.

Performance Improvement Projects (PIPs)

Table 3-6 presents a summary of the validation results for the 15 MHPs. The table delineates each of the 10 activities from the CMS protocol, shows the number of MHPs meeting all of the evaluation requirements within each of the 10 activities, and presents the number of MHPs that have reached each activity. The table further shows the number of MHPs meeting the critical elements within each of the 10 activities.

Table 3-6—Summary of Data From the Validation of 2005–2006 Blood Lead Testing PIPs

Validation Activity	Number of PIPs Meeting all Evaluation Elements/Number Reviewed	Number of PIPs Meeting all Critical Elements/Number Reviewed
Activity I—Appropriate Study Topic	15/15	15/15
Activity II—Clearly Defined, Answerable Study Question	15/15	15/15
Activity III—Clearly Defined Study Indicator	13/15	13/15
Activity IV—Correctly Identified Study Population	15/15	15/15
Activity V—Valid Sampling Techniques	15/15	15/15
Activity VI—Accurate/Complete Data Collection	10/15	NA for all MHPs
Activity VII—Appropriate Improvement Strategies	14/14	14/14
Activity VIII—Sufficient Data Analysis and Interpretation	8/14	14/14
Activity IX—Real Improvement Achieved	8/14	No Critical Elements
Activity X—Sustained Improvement	4/7	No Critical Elements

All of the MHPs received a validation status of *Met* or *Partially Met* for the Blood Lead Testing PIP, demonstrating the capability to measure performance and implement and evaluate systematic interventions. The MHPs were at various stages of demonstrating the effectiveness of interventions, along with sustained improvement.

Overall, performance was considered above average for conducting PIPs. The table shows high performance in the introductory and early activities, with increasing opportunities for improvement in the later activities. The results from Table 3-6 suggest that certain activities are well-understood by the MHPs (i.e., Activities I, II, IV, V, and VII) and should be considered strengths statewide. Other activities were not as well-understood or documented across the MHPs (i.e., Activities VI, VIII, IX, and X). For example, only four of seven MHPs that reached the final activity passed all of the elements within it. For these reasons, these activities were seen as statewide opportunities for improvement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for the statewide composite CAHPS scores are shown in Table 3-7. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table 3-7—Detailed State Average Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	67.6%	71.3%	2.53	2.59	★★
Getting Care Quickly	43.6%	45.2%	2.15	2.18	★★
How Well Doctors Communicate	57.7%	59.4%	2.42	2.45	★★
Courteous and Helpful Office Staff	63.7%	66.0%	2.50	2.54	★★
Customer Service	62.9%	69.0%	2.51	2.60	★★★

Note: Top box denotes the percentage who responded "Always" or "Not a Problem."

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 3-7 shows that all five of the top box composite score percentages and three-point means showed improvement in 2005 over 2004. For 2005 statewide, the performance level was above average from a national perspective for one measure, Customer Service. The other four measures were assessed as about average from a national perspective. On balance, all of the rates and means improved, but there were still ample opportunities for improvement for the measures scoring about average from a national perspective (i.e., Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Courteous and Helpful Office Staff).

The scores for global ratings are presented in Table 3-8. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table 3-8—Detailed State Average Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	55.7%	57.8%	2.39	2.43	★★
Rating of Specialist	58.7%	59.4%	2.42	2.43	★★
Rating of All Health Care	49.1%	52.6%	2.28	2.33	★★
Rating of Health Plan	42.9%	49.9%	2.15	2.28	★★

Note: Top satisfaction denotes the percentage of respondents rating 9 or 10 on a scale of 0 to 10.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 3-8 shows that all four measures improved from 2004 to 2005. Yet, the 2005 scores for all four measures were about average from a national perspective. This finding suggested opportunities for improvement for all four of the global ratings even though the improvements would be building on prior gains.

The data used to create these tables presented one more finding from an overall evaluation of the results. Two MHPs had the lowest score for three measures, although ties for lowest score occurred for two of the nine measures. These two MHPs were **MCD** and **PMD**. For this reason, it is suggested that opportunities for improvement be a higher priority for these two MHPs than for the other 13 MHPs from the results of the CAHPS assessment.

The State met its objective of obtaining information on members' levels of satisfaction with their health care experience. While member satisfaction showed improvement compared with 2004, eight of nine CAHPS rates showed average satisfaction compared with national Medicaid rates. All nine measures offered additional opportunities for improvement with member satisfaction.

Conclusions/Summary

The current review of the MHPs showed both strengths and opportunities for improvement statewide. Opportunities for improvement specific to each MHP are discussed in Appendices A–O. For best practices, also highlighted in Appendices A–O, MDCH might consider various methods to generalize the policies and practices responsible for exemplary performance throughout the State.

For the annual compliance review, the Administrative and Member categories showed the highest performance statewide, and 14 of 15 MHPs achieved a perfect score in these categories. By contrast, two MHPs achieved perfect scores for the Quality Assurance/Utilization Review and three MHPs achieved perfect scores for the Fraud and Abuse categories. This finding suggested that these categories were high-priority opportunities for improvement for MHPs statewide, followed by the MIS/Data Reporting/Claims Processing category and the Provider category.

In performance measures, both Combo 2 immunization rates (i.e., Children and Adolescents) emerged as strengths across the State, especially the adolescent rate, which increased from 34.5 percent to 54.7 percent between the 2004 and 2005 assessments. Four measures were shown to be high-priority opportunities for improvement statewide. These measures were: Breast Cancer Screening; Well-Child 1st 15 Months, 0 Visits; and Children's Access (25 Months–6 Years and 7–11 Years).

The PIP evaluation showed higher performance in the introductory and earlier activities, with increasing opportunities for improvement in the later activities statewide. The CMS protocol (Conducting Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities) contains the needed information and examples to assist the MHPs in overcoming their difficulties in the middle and later stages of conducting and documenting a PIP.

The CAHPS evaluation showed generally improving but still about average performance from a national perspective. Overall, Customer Service was the only one of nine measures to average above the 75th national percentile, demonstrating a relative strength statewide. No measure averaged below the 25th national percentile.

Overall, plans performed well on PIPs and the annual compliance reviews. Both of these areas, which tend to focus on documentation of processes, should be regarded as MHP strengths. Although the performance measures showed average performance (i.e., between the national 25th and 75th percentiles), in general, these measures also offered the most opportunity for improvement. Since the performance of each MHP was relatively similar, conducting a statewide collaborative study may improve rates at the statewide and the MHP performance level.

4. Appendices Introduction

Overview

This Appendices section of the report summarizes MHP-specific key findings and recommendations for the three mandatory EQR-related activities: validation of performance measures, validation of PIPs, and compliance monitoring. In addition, CAHPS results are presented. For a more detailed description of the results of the mandatory EQR-related activities, refer to the aggregate and MHP-specific reports, including:

- Reports of site-visit findings for each MHP
- Michigan Medicaid HEDIS 2005 results reports
- 2006 PIP validation reports

Michigan Medicaid Health Plan Names

MDCH uses a three-letter acronym for each MHP. The acronyms are illustrated in Table 4-1 and used throughout this report.

Table 4-1—Michigan MHP Formal Names, Abbreviations, and Appendix Letter Assignment

MHP Name	Abbreviation	Appendix Letter Assignment
Cape Health Plan	CAP	A
Community Choice Michigan	CCM	B
Great Lakes Health Plan	GLH	C
Health Plan of Michigan, Inc.	HPM	D
HealthPlus Partners, Inc.	HPP	E
M-CAID	MCD	F
McLaren Health Plan	MCL	G
Midwest Health Plan	MID	H
Molina Healthcare of Michigan	MOL	I
OmniCare Health Plan	OCH	J
Physicians Health Plan of Mid-Michigan Family Care	PMD	K
Physicians Health Plan of Southwest Michigan	PSW	L
Priority Health Government Programs, Inc.	PRI	M
Total Health Care, Inc.	THC	N
Upper Peninsula Health Plan	UPP	O

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table A-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 2/2 represents two out of a total of two standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table A-1—CAP Detailed Scores for Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for CAP		State Average
	Number	Percent	
Administrative	2/2	100%	97.0%
Provider	7/8	87.5%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	3/4	75.0%	82.8%
MIS/Data Reporting/Claims Processing	4/4	100%	85.5%
Fraud and Abuse	9/11	81.8%	86.1%

The table shows that **CAP**'s rates exceeded the statewide average for three of the categories of measures: Administrative, Member, and MIS/Data Reporting/Claims Processing. These categories were apparent strengths.

The other three standards (i.e., Provider, Quality/Utilization, and Fraud and Abuse) were relative opportunities for improvement. Functionally, however, the opportunity for improvement was limited. For Provider, the **CAP** rate of 87.5 percent was functionally equivalent to the statewide average of 88.5 percent because there were only eight elements to the standard, seven of which were passed by **CAP**. To do any better, **CAP** would need to achieve a perfect score for the category. Functionally, the same situation existed for Quality/Utilization. For Fraud and Abuse, however, the plan could have scored somewhat better than the statewide average without a perfect score.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table A-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table A-2—CAP Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	64.0%	71.7%	★★★
Adolescent Immunization Combo 2	31.9%	51.9%	★★★
Appropriate Treatment for Children With URI	75.5%	75.5%	★★
Breast Cancer Screening	52.4%	54.7%	★★
Cervical Cancer Screening	62.6%	60.7%	★★
Controlling High Blood Pressure	58.9%	60.1%	★★
Chlamydia Screening, 16–20 Years	48.2%	41.8%	★★
Chlamydia Screening, 21–26 Years	52.2%	45.9%	★★
Chlamydia Screening (Combined)	50.2%	43.8%	★★
Diabetes Care—HbA1c Testing	75.5%	71.4%	★★
Diabetes Care—Poor HbA1c Control*	53.6%	48.3%	★★
Diabetes Care—Eye Exam	41.3%	44.0%	★★
Diabetes Care—LDL-C Screen	80.2%	84.1%	★★★
Diabetes Care—LDL-C Level <130	49.4%	54.9%	★★
Diabetes Care—LDL-C Level <100	30.5%	31.7%	★★
Diabetes Care—Nephropathy	33.6%	37.9%	★★
Asthma 5–9 Years	57.8%	58.4%	★★
Asthma 10–17 Years	55.0%	49.8%	★
Asthma 18–56 Years	69.2%	66.1%	★★
Asthma Combined Rate	62.9%	59.9%	★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table A-2—CAP Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Medical Assistance With Smoking Cessation	63.6%	66.6%	★★
Well-Child 1st 15 Months, 0 Visits*	6.2%	6.0%	★
Well-Child 1st 15 Months, 6+ Visits	34.9%	37.2%	★
Well-Child 3rd–6th Years of Life	66.0%	66.3%	★★
Adolescent Well-Care Visits	46.4%	46.4%**	★★★
Timeliness of Prenatal Care	67.7%	68.5%	★
Postpartum Care	40.4%	46.3%	★
Children's Access 12–24 Months	93.3%	91.2%	★★
Children's Access 25 Months–6 Years	81.0%	75.7%	★
Children's Access 7–11 Years	78.9%	78.3%	★★
Adolescents' Access 12–19 Years	77.8%	75.9%	★★
Adults' Access 20–44 Years	71.0%	71.2%	★★
Adults' Access 45–64 Years	79.5%	78.8%	★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table A-2 shows that **CAP**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for four performance measures (Childhood Immunization Status—Combo 2, Adolescent Immunization Status—Combo 2, Comprehensive Diabetes Care: LCL-C Screening, and Adolescent Well-Care Visits). These measures represented relative areas of strength for **CAP**.

The table also shows that the rates for 21 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Eight rates were below national Medicaid HEDIS 2004 25th percentiles. These rates were: Asthma (10 to 17 Years and Combined Rate), Well-Child Visits First 15 Months (0 Visits and 6+ Visits), Timeliness of Prenatal Care, Postpartum Care, Children's Access 25 Months–6 Years, and Adults' Access 45–64 Years. Rates for these measures, when compared with national results, represented relative opportunities for improvement for **CAP**.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, one measure was rotated from 2004 and, therefore, is not included in this evaluation. The rates improved or remained the same for 19 of the 32 (59.4 percent) nonrotated performance measures compared with rates reported in 2004. The rates decreased for 12 (37.5 percent) of the performance measures compared with 2004.

Validation of Performance Improvement Projects (PIPs)

CAP's results for the Blood Lead Testing PIP are presented in Table A-3 and Table A-4. Table A-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. **CAP** achieved a *Met* validation status with an overall score of 98 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table A-3—Overall PIP Scores *for* CAP	
Percentage Score of Critical Elements Met	**100%**
Percentage Score of Evaluation Elements Met	**98%**
Validation Status	***Met***

Table A-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or *NA*.

Table A-4—PIP Activity Scores *for* CAP						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	4	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	1	0
IX.	Real Improvement Achieved	4	4	0	0	0
X.	Sustained Improvement Achieved	1	1	0	0	0
Totals for all Activities		**53**	**46**	**0**	**1**	**6**

For all 53 PIP elements evaluated, 46 were *Met*, zero were *Partially Met*, 1 was *Not Met*, and 6 were *NA*. The findings indicated that **CAP** understood the PIP process and was able to conduct and produce valid PIPs. Of the 47 scored elements (i.e., 53 total elements minus the 6 that were *NA*), **CAP** scored a *Met* on all but one. An opportunity for improvement existed in Activity VIII, Sufficient Data Analysis and Interpretation.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **CAP**'s composite CAHPS scores are shown in Table A-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table A-5—CAP Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	66.9%	73.4%	2.52	2.63	★★
Getting Care Quickly	44.2%	48.0%	2.17	2.20	★★
How Well Doctors Communicate	57.8%	59.5%	2.41	2.43	★★
Courteous and Helpful Office Staff	64.7%	66.2%	2.53	2.52	★★
Customer Service	NA	70.1%	NA	2.58	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that the four top box percentages reported in 2004 all showed improvement for 2005 (Customer Service did not have a sufficient number of respondents for 2004). For 2005, the performance level was average for all five measures compared with the national Medicaid percentiles. These twin findings suggested that somewhat small improvements were made between 2004 and 2005, but there was still an opportunity for improvement in all five measures.

CAP's detailed scores for global ratings are presented in Table A-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table A-6—CAP Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	54.0%	51.5%	2.38	2.34	★
Rating of Specialist	60.1%	59.4%	2.42	2.41	★★
Rating of All Health Care	49.1%	51.2%	2.28	2.30	★★
Rating of Health Plan	42.1%	48.0%	2.09	2.23	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that the rates for All Health Care and Rating of Health Plan increased compared with 2004. Yet, the overall performance level was average for both of these measures. Combined, these results suggested that credit should be given for the increases, but the areas still represent opportunities for improvement.

The table also shows that Rating of Personal Doctor and Rating of Specialist had declined from 2004. Moreover, the performance level for Rating of Personal Doctor was below the national Medicaid 25th percentile, while the other three measures were assessed as average from a national perspective. These results strongly suggested opportunities for improvement, perhaps starting with Rating of Personal Doctor.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

In the on-site reviews reported in FY 2005, **CAP** was the only MHP to demonstrate full compliance with Medicaid contract requirements, with a *Pass* score on all criteria reviewed. It was suggested that it might be appropriate for MDCH to explore best practice options with this MHP to ensure ongoing performance across multiple areas and topics. No opportunities for improvement were identified; therefore, a corrective action plan was not required.

CAP conducted an evaluation of 2003 QI activities and developed a 2004 Work Plan designed to support the plan's continuing focus on QI efforts. The documents provided a high-level overview and focused on actions taken and tasks to be performed. It was suggested that using a more data-driven approach to quality improvement program (QIP) activities and evaluating performance against goals on a more detailed level could enhance the value of this program to the organization. One of the significant milestones reported in **CAP**'s 2005 QI evaluation was the use of the Catalyst Technology (CT) System in 2005 to perform HEDIS 2005 activities. Disease management programs for diabetes and asthma were developed and implemented in 2004, and HEDIS data were used to assess performance against goals.

Performance Measures

It was recommended that **CAP** consider ensuring that internal quality monitors coincide with those used by MDCH. For example, the health plan should consider switching to rates for Zero Visits and 6 or More Visits for Well-Child Visits in the First 15 Months of Life to be in line with MDCH standards, instead of the 1+ visit rate that was used as a quality indicator. **CAP** implemented this recommendation in the goals and performance for well-child visits included in its 2005 QI evaluation.

It was further recommended that **CAP** reexamine the Maternal Infant Health program and consider additional outreach and education to this population. In 2005, the QI Department continued the Women's Health Program to increase prenatal and postpartum care, and continued the incentive program to encourage members to obtain a postpartum examination within 21 to 56 days after delivery.

Performance Improvement Projects (PIPs)

CAP showed opportunities for improvement in its 2004–2005 Childhood Immunization PIP in Activity VIII, Element 7, "Reporting statistical difference between measurement periods." Its 2005–2006 Blood Lead Testing PIP showed improvement in this area. Although the topics differed, **CAP** provided statistical testing between measurement periods.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In 2004, one global rating measure—Rating of Health Plan—fell below the NCQA national 25th percentile, and the remaining global ratings and composite scores were between the 25th and 50th percentiles. These findings reinforced the opportunities for improvement identified from the HEDIS results. There was no mention of CAHPS scores in **CAP**'s 2005 QI Annual Evaluation and Effectiveness Report due to the timing of the release of those scores.

Conclusions and Recommendations

The current review of **CAP** showed both strengths and opportunities for improvement. The results from the annual compliance review and the current PIP assessment represented definite areas of strength for **CAP**. Performance in these areas was, or at least approached, a best practice. MDCH might want to consider various methods to generalize the policies and practices at **CAP** that seemed responsible for the exemplary performance in these areas.

From the compliance reviews, Administrative, Member, and MIS/Data Reporting/Claims Processing each scored 100 percent and were viewed as areas of relative strength. Nonetheless, **CAP** should continue to use processes to guard against fraud and abuse committed by employees, providers, and members, as well as expand its processes to include claims editing, interrater reliability, recoupment of inappropriately paid funds, beneficiary lock-in, etc. Further, while **CAP**'s policies contain definitions of fraud and abuse, the definition of fraud is not exactly as stated in 42 CFR 455.2. **CAP** should address this discrepancy.

CAP should continue to provide, at least annually, education to employees, providers, and members regarding the detection of fraud and abuse. That education should include fliers, employee newsletters, employee handbooks, the **CAP** Web site, the provider handbook, provider newsletters, the member handbook, and member newsletters. Information should state that fraud and abuse may be reported anonymously and include the addresses and telephone numbers necessary for reporting to the plan and to the MDCH Program Investigation Section (MDCH/PIS).

For the performance measures, relative areas of strength included Childhood Immunization Status—Combo 2, Adolescent Immunization Status—Combo 2, Comprehensive Diabetes Care: LCL-C Screening, and Adolescent Well-Care Visits. For these four measures, **CAP**'s rates were above the national Medicaid HEDIS 2004 75th percentile.

Opportunities for improvement existed for the performance measures. Of these opportunities, perhaps the most important were the measures that were in need of improvement from the prior year and were still in need of improvement during the current assessment, as well as the measures that were below the national Medicaid 25th percentile. For the performance measures, the targeted measures would be: Use of Appropriate Medications for People with Asthma (10 to 17 Years and Combined Rate), Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits), Timeliness of Prenatal Care, Postpartum Care, Children's Access to Primary Care Practitioners (25 Months to 6 Years), and Adults' Access to Preventive/Ambulatory Health Services (45 to 64 Years).

PIPs were an area of strength. The only opportunity for improvement was in the data analysis and interpretation activity, where **CAP** did not meet the requirements of one of nine elements within the activity.

For CAHPS, recommendations coinciding with opportunities for improvement included identifying and addressing the key drivers for each measure and exploring ways in which HEDIS and CAHPS issues might be addressed in tandem. For example, it was noted that strengthening **CAP**'s Maternal Infant Health Program has the potential to improve members' experiences in ways that could be reflected in CAHPS scores. It was suggested that **CAP** might convene a QI work group to determine which individual survey questions would make the best targets for QI activities. In addition, the Rating of Personal Doctor has been an ongoing opportunity for improvement.

For the domains of Quality, Timeliness, and Access, the averages for **CAP** were similar to the statewide averages, indicating overall average performance. None of the differences between the **CAP**'s scores and the statewide averages was substantively large. Within each of the three domains, the scores for performance measures showed the greatest opportunity for improvement. These findings indicated that **CAP** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table B-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 3/3 represents three out of a total of three standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table B-1—CCM Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for CCM		State Average
	Number	Percent	
Administrative	3/3	100%	97.0%
Provider	6/7	85.7%	88.5%
Member	4/4	100%	93.9%
Quality/Utilization	4/5	80.0%	82.8%
MIS/Data Reporting/Claims Processing	2/2	100%	85.5%
Fraud and Abuse	8/11	72.7%	86.1%

The table shows that **CCM** achieved perfect scores for three of the six categories of compliance review measures: Administrative, Member, and MIS/Data Reporting/Claims Processing. These three categories were recognized strengths for **CCM**. For two of the remaining six categories (i.e., Provider and Quality/Utilization), **CCM**'s score was functionally equivalent to the statewide averages, although the rates appeared a bit lower. This equivalence exists because of the relatively small number of elements in each category of measures. To do any better on these two elements, **CCM** would have needed perfect scores, which would be substantially above the statewide averages of 88.5 percent and 82.8 percent for Provider and Quality/Utilization, respectively.

The sixth category (i.e., Fraud and Abuse) presented a larger opportunity for improvement than the other categories for two reasons. First, the rate was substantively lower than the other **CCM** rates. Second, **CCM**'s rate of 72.7 percent is substantively lower than the statewide average rate of 86.1 percent. Unlike the situation where Provider and Quality/Utilization appeared a bit lower than the statewide averages but were functionally equivalent, **CCM** could have passed more elements without also needing to achieve a perfect score. **CCM** could have passed an additional element and still been a bit lower than the statewide average. Furthermore, passing a second additional element (i.e., 10 of 11) would still not have required a perfect score.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table B-2. The table shows each of the performance measures, the rates for each measure for 2004 and for 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table B-2—CCM Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	65.7%	69.3%	★★★
Adolescent Immunization Combo 2	37.7%	54.0%	★★★
Appropriate Treatment for Children With URI	75.9%	77.5%	★★
Breast Cancer Screening	54.3%	49.9%	★
Cervical Cancer Screening	69.8%	67.6%	★★
Controlling High Blood Pressure	59.3%	65.0%	★★★
Chlamydia Screening, 16–20 Years	43.4%	48.7%	★★
Chlamydia Screening, 21–26 Years	51.6%	55.6%	★★
Chlamydia Screening (Combined)	47.5%	52.0%	★★
Diabetes Care—HbA1c Testing	74.5%	83.7%	★★
Diabetes Care—Poor HbA1c Control*	59.4%	41.6%	★★
Diabetes Care—Eye Exam	29.4%	38.4%	★★
Diabetes Care—LDL-C Screen	58.4%	71.8%	★★
Diabetes Care—LDL-C Level <130	26.3%	47.9%	★★
Diabetes Care—LDL-C Level <100	17.3%	32.6%	★★
Diabetes Care—Nephropathy	37.7%	43.1%	★★
Asthma 5–9 Years	62.8%	70.0%	★★★
Asthma 10–17 Years	66.4%	65.4%	★★
Asthma 18–56 Years	71.3%	74.0%	★★★
Asthma Combined Rate	68.2%	70.9%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results

Table B-2—CCM Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Medical Assistance With Smoking Cessation	64.8%	69.1%	★★★
Well-Child 1st 15 Months, 0 Visits*	3.9%	5.4%	★
Well-Child 1st 15 Months, 6+ Visits	31.6%	41.4%	★★
Well-Child 3rd–6th Years of Life	54.3%	54.3%**	★★
Adolescent Well-Care Visits	33.3%	33.3%**	★★
Timeliness of Prenatal Care	72.5%	75.7%	★★
Postpartum Care	47.7%	58.9%	★★
Children's Access 12–24 Months	90.5%	84.8%	★
Children's Access 25 Months–6 Years	74.9%	77.1%	★
Children's Access 7–11 Years	75.7%	77.1%	★
Adolescents' Access 12–19 Years	73.9%	75.4%	★★
Adults' Access 20–44 Years	74.4%	76.2%	★★
Adults' Access 45–64 Years	83.5%	83.2%	★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results

Table B-2 shows that **CCM**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for seven performance measures (i.e., Childhood and Adolescent Immunization Combo 2, Controlling High Blood Pressure, Asthma 5-9 Years, Asthma 18-56 Years, Asthma Combined Rate, and Medical Assistance With Smoking Cessation). These measures represented relative areas of strength for **CCM**.

The table also shows that rates for 21 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Five rates were below national Medicaid HEDIS 2004 25th percentiles. These rates were: Breast Cancer Screening; Well-Child 1st 15 Months, 0 Visits; Children's Access 12–24 Months; Children's Access 25 Months–6 Years; and Children's Access 7–11 Years. These measures represented relative opportunities for improvement for **CCM** compared with national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, two measures were rotated from 2004 and, therefore, were not included in this evaluation. The rates improved or remained the same for 27 of the 31 (87.1 percent) nonrotated performance measures compared with rates reported in 2004. The rates decreased for six (19.4 percent) of the performance measures compared with 2004.

Validation of Performance Improvement Projects (PIPs)

CCM's results for the Blood Lead Testing PIP are presented in Table B-3 and Table B-4. Table B-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. Furthermore, **CCM** achieved a *Met* validation status with an overall score of 100 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table B-3—Overall PIP Scores *for* CCM	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**100%**
Validation Status	***Met***

Table B-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table B-4—PIP Activity Scores *for* CCM						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	3	0	0	1
VIII.	Sufficient Data Analysis and Interpretation	9	9	0	0	0
IX.	Real Improvement Achieved	4	4	0	0	0
X.	Sustained Improvement Achieved	1	1	0	0	0
Totals for all Activities		**53**	**46**	**0**	**0**	**7**

For the 53 PIP elements, 46 were *Met*, none was *Partially Met* or *Not Met*, and seven were *NA*. The findings indicated that **CCM** understood the PIP process and was able to conduct and produce a well-documented PIP, having achieved a score of *Met* on every applicable element within every activity.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **CCM**'s composite CAHPS scores are shown in Table B-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table B-5—CCM Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	68.0%	68.8%	2.52	2.52	★★
Getting Care Quickly	48.0%	47.4%	2.10	2.21	★★
How Well Doctors Communicate	57.0%	62.2%	2.40	2.49	★★
Courteous and Helpful Office Staff	61.0%	67.4%	2.48	2.55	★★
Customer Service	NA	NA	NA	NA	NA

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that two of top box percentages reported in 2004 and 2005 improved (Customer Service did not have a sufficient number of respondents for 2004 or for 2005) and two remained about the same. For 2005, the performance level was average for the four reported measures compared with the national Medicaid percentiles. These twin findings suggested that somewhat small improvements were made between 2004 and 2005, but an opportunity for improvement still existed in the four reported measures.

CCM's detailed scores for global ratings are presented in Table B-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table B-6—CCM Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	51.1%	60.4%	2.34	2.51	★★★
Rating of Specialist	56.4%	63.4%	2.37	2.47	★★
Rating of All Health Care	48.4%	52.3%	2.25	2.30	★★
Rating of Health Plan	40.7%	48.2%	2.09	2.22	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all four measures improved from 2004 to 2005. Moreover, the performance level for Rating of Personal Doctor was above the national Medicaid 75th percentile, while the other three measures were about average from a national perspective. These three average-performing measures (i.e., Rating of Specialist, Rating of All Health Care, and Rating of Health Plan) represented ongoing opportunities for improvement.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

CCM's on-site review results reported in FY 2005 showed both performance strengths and opportunities for improvement. The plan's strengths were in the core areas of Administrative, Member, and Quality Assurance/Utilization Review. The results indicated that **CCM** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; and programs for individuals with special health care needs. **CCM** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider, MIS/Data Reporting/Claims Processing, and Fraud and Abuse. **CCM** plans were deemed acceptable by MDCH in terms of scope, content, and established timeline, with one exception indicated below. The action plan submitted to MDCH required that the plan:

- Modify its provider directory to include the name and address of all contracted independent pharmacies. This corrective action was not acceptable as submitted to MDCH because **CCM** was not clear as to whether independent pharmacy phone numbers would be included in the provider directory. **CCM** was asked to submit documentation to MDCH that demonstrated that **CCM**'s provider directory would include the phone numbers of independent pharmacies. During the April 2005 on-site visit, **CCM** provided the revised provider directory that included all contracted providers.
- Develop a process to ensure that **CCM** submits all required reports before or on the due date. During the 2004 on-site visit, **CCM** received a score of *Fail* on this criterion because three of the required reports for the review period were submitted after the due date. A table compiled for the April 2005 on-site visit illustrated the required reports for the review period, the due date for the reports, and the date the reports were submitted by **CCM**. Based on this information, it was concluded that **CCM** had submitted all required reports prior to or on the due date since the previous on-site visit.
- Pay 90 percent of clean claims within 30 days and maintain an ending inventory with less than or equal to 2 percent of unprocessed claims greater than 45 days old. In the interim, **CCM** was to provide monthly reports to MDCH on its progress toward eliminating the claims backlog. The April 2005 on-site visit found that in October 2004, **CCM** had met the claims processing standards of 90 percent of clean claims processed in 30 days and an ending inventory with less than 2 percent of unprocessed claims more than 45 days old.
- Begin using or adapt the current processes/reports specified in the plan's process to detect and eliminate fraud and abuse by providers. If fraud or abuse is noted, the plan's committee meeting minutes should reflect discussion of the provider's issue(s) and any corrective plan instituted. **CCM** should notify MDCH/Program Investigation Section (PIS) of any instance of provider fraud or abuse. For the April 2005 on-site review, **CCM** provided evidence that the plan had mechanisms in effect, demonstrated use of a process to detect both under- and overutilization of services, and that demonstrated it uses this information to identify potential fraud and abuse.

- Begin using or adapt the current processes/reports specified in the plan's process to detect and eliminate fraud and abuse by members. If fraud or abuse is noted, the plan's committee meeting minutes should reflect discussion of the member's issue(s) and any corrective plan instituted. **CCM** should notify MDCH/PIS of any instance of member fraud or abuse. The evidence (described above) presented during the April 2005 on-site review included a document, "CSMG for CCM Procedure: Fraud and Abuse," and a 2004 Performance Improvement Work Plan Evaluation Worksheet. The procedure followed by the pharmacy department to review for overutilization of narcotic prescriptions was outlined. The worksheet was used by the pharmacy to document the outcomes of the pharmacy claims review of members receiving 18 or more controlled substances in a 12-month period.

CCM's 2003 Quality Improvement Program Annual Summary and Effectiveness Review indicated that a well-defined fraud and abuse program was implemented in the fourth quarter of 2003 and that all staff members attended an in-service for fraud and abuse reporting. The 2004 QI Work Plan included eight action steps related to fraud and abuse. However, as noted in MDCH's 2004 on-site review report, opportunities for improvement continued to exist in this area. The April 2005 on-site review report recommended that **CCM** continue to review all claims—for members and providers—for over- and underutilization, with a focus on identifying potential fraud and abuse.

Performance Measures

In FY 2005, it was suggested that **CCM** reevaluate its outreach program for children's preventive care and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visits. **CCM**'s 2006 QI Work Plan included steps designed to increase the health knowledge base for children and families, improve HEDIS results related to EPSDT components, provide training/education to PCPs, and determine the most effective means of outreach to members.

There was some concern in FY 2005 about the slightly below-average rates for Timeliness of Prenatal Care and Postpartum Care. It was recommended that **CCM** reexamine the maternity-focused activities of the QI program to ensure that performance in these areas is addressed. **CCM**'s Medicaid Managed Care Monitoring Report, dated January 2005, indicated that the plan had met the Prenatal Care standard of 72 percent by achieving a score of 73 percent.

While there were diabetes outreach mailings and an initiative to provide glucometers in 2004-2005, there did not appear to be an organized diabetes disease management program. The low reported rates in this area suggested the need for such a program. **CCM**'s 2006 QI Work Plan included a diabetes chronic disease initiative.

Performance Improvement Projects (PIPs)

CCM showed opportunities for improvement in its 2004-2005 Well-Child Visits Ages 3 to 6 Years PIP in Activity 9, Element 2, "Documented improvement in processes of care;" Activity 9, Element 3, "Improvement as a result of the interventions;" Activity 9, Element 4, "Statistical evidence that improvement was true improvement;" and Activity 10, Element 1, "Evidence of sustained improvement." Its 2005-2006 Blood Lead Testing PIP showed improvement in all four areas.

Although the topics differed, **CCM** documented improvements in outcomes of care, described improvements in lead testing rates related to interventions, showed statistical evidence that the improvement was true improvement, and showed sustained improvement in testing rates.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CCM's 2004 CAHPS results showed three global ratings and three composite scores that were below the national 25th percentile. The only areas that fell between the 25th and 50th percentiles were Rating of All Health Care and Getting Needed Care. These findings were consistent with the opportunities for improvement suggested by **CCM**'s HEDIS results. For example, it was recommended that targeted interventions in the areas of maternity care and diabetes care might result in quality improvements that would be reflected in future CAHPS scores. Specific CAHPS measures could also be targeted to identify and address the key drivers of each measure. **CCM**'s 2006 QI Work Plan did not address this recommendation.

Conclusions and Recommendations

The current review of **CCM** showed both strengths and opportunities for improvement. The results from the annual compliance review and from the current PIP assessment represented definite areas of strength for **CCM** that were, or at least approached, best practices. MDCH might want to consider various methods to generalize the policies and practices at **CCM** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **CCM** should continue to work with providers in counties in which **CCM** would like to expand the plan's provider network. Additionally, **CCM** should continue to review all claims for members and providers for over- and underutilization, with a focus on identifying potential fraud and abuse.

CCM should continue to provide, at least annually, education to employees, providers, and members regarding the detection of fraud and abuse. The education should include fliers, employee newsletters, employee handbooks, the **CCM** Web site, the provider handbook, provider newsletters, the member handbook, and member newsletters. Information should state that fraud and abuse may be reported anonymously and should include the addresses and telephone numbers necessary for reporting to the plan and to the MDCH/PIS.

From the assessment of the performance measures, seven rates were above the national Medicaid HEDIS 2004 75th percentiles: Childhood Immunization Combo 2, Adolescent Immunization Combo 2, Controlling High Blood Pressure, Asthma 5–9 Years, Asthma 18–56 Years, Asthma Combined Rate, and Medical Assistance With Smoking Cessation. These measures represented relative areas of strength for **CCM**. Nonetheless, **CCM** should focus on five measures as opportunities for improvement: Breast Cancer Screening; Well-Child 1st 15 Months, 0 Visits; Children's Access 12–24 Months, Children's Access 25 Months–6 Years, and Children's Access 7–11 Years. These measures all scored below the national Medicaid HEDIS 2004 25th percentiles.

Furthermore, **CCM** should focus improvement efforts on the six measures that declined between measurement years. These measures were: Breast Cancer Screening; Cervical Cancer Screening; Asthma 10–17 years; Well-Child 1st 15 Months, 0 Visits; Children's Access 12–24 Months, and Adult's Access 45–64 Years.

PIPs were shown to be an area of strength. **CCM** scored 100 percent on all elements—evidence of an area of strength and a potential best practice.

The assessment of the CAHPS scores pointed to Rating of Personal Doctor as an area of strength. This measure scored above the national Medicaid 75th percentile. Nonetheless, performance on the remaining measures was about average from a national perspective. This average performance for all but one measure suggested continued opportunities for improvement. For example, **CCM** should strive to improve the CAHPS score for Getting Needed Care, which had a three-point mean that remained unchanged from 2004 to 2005.

For the domains of Quality, Timeliness, and Access, the averages for **CCM** approximated the statewide averages, demonstrating overall average performance. None of the differences between **CCM**'s scores and the statewide averages was substantively large. These findings indicated that **CCM** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table C-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 5/5 represents five out of a total of five standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table C-1—GLH Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for GLH		State Average
	Number	Percent	
Administrative	5/5	100%	97.0%
Provider	7/7	100%	88.5%
Member	2/2	100%	93.9%
Quality/Utilization	3/4	75.0%	82.8%
MIS/Data Reporting/Claims Processing	2/4	50.0%	85.5%
Fraud and Abuse	11/11	100%	86.1%

The table shows that **GLH** achieved perfect scores on four of the six categories of measures: Administrative, Provider, Member, and Fraud and Abuse. These areas were recognized strengths for **GLH** and may represent best practices.

The two scores below 100 percent were Quality/Utilization at 75.0 percent and MIS/Data Reporting/Claims Processing at 50 percent. The results for Quality/Utilization could either have been under the statewide average of 82.8 percent by **GLH** not meeting a single element, as happened, or the score could have been 100 percent, due to the small number of elements in the category. The situation for MIS/Data Reporting/Claims Processing, however, was somewhat different. **GLH** passed two of the four elements in the category. Passing an additional (i.e., third) element would still have resulted in **GLH** scoring lower then the statewide average. For this reason, MIS/Data Reporting/Claims Processing was viewed as a higher-priority opportunity for improvement than Quality/Utilization. Specifically, **GLH** must adhere to its processes and policies and submit all reports and financial statements in a timely manner.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and to determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table C-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table C-2—GLH Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	59.7%	68.3%	★★★
Adolescent Immunization Combo 2	33.6%	51.8%	★★★
Appropriate Treatment for Children With URI	68.4%	70.6%	★
Breast Cancer Screening	48.7%	54.3%	★★
Cervical Cancer Screening	51.0%	59.6%	★★
Controlling High Blood Pressure	44.7%	47.4%	★
Chlamydia Screening, 16–20 Years	35.7%	47.2%	★★
Chlamydia Screening, 21–26 Years	42.4%	52.1%	★★
Chlamydia Screening (Combined)	38.8%	49.4%	★★
Diabetes Care—HbA1c Testing	77.6%	79.0%	★★
Diabetes Care—Poor HbA1c Control*	47.0%	46.3%	★★
Diabetes Care—Eye Exam	45.3%	45.0%	★★
Diabetes Care—LDL-C Screen	80.3%	81.4%	★★
Diabetes Care—LDL-C Level <130	53.5%	67.1%	★★★
Diabetes Care—LDL-C Level <100	31.3%	60.1%	★★★
Diabetes Care—Nephropathy	38.3%	47.0%	★★
Asthma 5–9 Years	46.6%	57.0%	★★
Asthma 10–17 Years	60.0%	57.9%	★
Asthma 18–56 Years	70.3%	73.7%	★★★
Asthma Combined Rate	62.8%	65.9%	★★
Medical Assistance With Smoking Cessation	59.6%	64.5%	★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table C-2—GLH Scores for Performance Measures			
Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Well-Child 1st 15 Months, 0 Visits*	3.5%	3.5%**	★★
Well-Child 1st 15 Months, 6+ Visits	39.4%	39.4%**	★★
Well-Child 3rd–6th Years of Life	56.3%	60.8%	★★
Adolescent Well-Care Visits	39.9%	40.4%	★★
Timeliness of Prenatal Care	66.9%	72.0%	★★
Postpartum Care	41.3%	51.1%	★★
Children's Access 12–24 Months	90.7%	91.4%	★★
Children's Access 25 Months–6 Years	77.8%	79.5%	★★
Children's Access 7–11 Years	79.1%	78.5%	★★
Adolescents' Access 12–19 Years	75.7%	77.5%	★★
Adults' Access 20–44 Years	75.0%	74.7%	★★
Adults' Access 45–64 Years	84.0%	83.2%	★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table C-2 shows that **GLH**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for five performance measures (Childhood and Adolescent Immunization Combo 2, Diabetes Care—LDL-C Level <130 and <100, and Asthma 18–56 Years). Notably, Diabetes Care—LDL-C Level <100 increased from 31.3 percent to 60.1 percent. These five measures represented relative areas of strength for **GLH**.

The table also shows that the rates for 25 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Three rates were below the national Medicaid HEDIS 2004 25th percentile. These rates were: Appropriate Treatment for Children With URI, Controlling High Blood Pressure, and Asthma 10–17 Years. These measures, when compared with national results, represented relative opportunities for improvement for **GLH**.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, two measures were rotated from 2004 and, therefore, were not included in this evaluation. The rates improved or remained the same for 26 of the 31 (83.9 percent) nonrotated performance measures compared with the rates reported in 2004. The rates decreased for five (16.1 percent) of the performance measures compared with 2004, although they were still about average from a national perspective. These five rates were: Diabetes Care—Eye Exam, Asthma—10–17, Children's Access 7–11 Years, Adults' Access 20–44 Years, and Adults' Access 45–64 Years. Three of the four measures with rates that declined were direct measures of access.

Validation of Performance Improvement Projects (PIPs)

GLH's results for the Blood Lead Testing PIP are presented in Table C-3 and Table C-4. Table C-3 shows that two critical elements that were determined to be *Partially Met* resulted in a critical element score of 83 percent. Overall, **GLH** achieved a *Partially Met* validation status with an overall score of 91 percent for its Blood Lead Testing PIP.

Table C-3—Overall PIP Scores *for* GLH	
Percentage Score of Critical Elements *Met*	**83%**
Percentage Score of Evaluation Elements *Met*	**91%**
Validation Status	***Partially Met***

Table C-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met*, *Partially Met*, *Not Met*, or scored as *NA*.

Table C-4—PIP Activity Scores *for* GLH					
Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I. Appropriate Study Topic	6	6	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	4	2	0	1
IV. Correctly Identified Study Population	3	3	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0
VI. Accurate/Complete Data Collection	11	5	1	0	5
VII. Appropriate Improvement Strategies	4	3	0	0	1
VIII. Sufficient Data Analysis and Interpretation	9	9	0	0	0
IX. Real Improvement Achieved	4	3	1	0	0
X. Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities	**53**	**41**	**4**	**0**	**8**

For all 53 PIP elements (including critical elements) evaluated, 41 were *Met*, four were *Partially Met*, 0 were *Not Met*, and eight were *NA*. The findings indicated **GLH** had difficulty with clearly defining the study indicators and data completeness within the data collection activity. These findings did not indicate that **GLH** was unable to conduct valid PIPs, but rather, **GLH** should improve the documentation of the description for the study indicators in future PIPs and also ensure that its next PIP meets all requirements for data completeness.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **GLH**'s composite CAHPS scores are shown in Table C-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table C-5—GLH Detailed Results for CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	65.3%	67.2%	2.47	2.52	★★
Getting Care Quickly	42.6%	43.7%	2.11	2.13	★★
How Well Doctors Communicate	57.1%	57.5%	2.39	2.40	★
Courteous and Helpful Office Staff	64.2%	66.9%	2.49	2.55	★★
Customer Service	NA	65.6%	NA	2.52	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that the four top box percentages reported in 2004 all showed improvement for 2005 (Customer Service did not have a sufficient number of respondents for 2004). For 2005, the performance level was average for four of the five measures compared with national Medicaid percentiles. The How Well Doctors Communicate measure was below the national Medicaid 25th percentile. These twin findings suggested that somewhat small improvements were made between 2004 and 2005, but an opportunity for improvement still existed in all five measures, especially How Well Doctors Communicate.

GLH's detailed scores for global ratings are presented in Table C-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table C-6—GLH Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	54.0%	64.1%	2.36	2.49	★★
Rating of Specialist	55.4%	70.5%	2.38	2.58	★★★
Rating of All Health Care	51.9%	63.7%	2.29	2.49	★★★
Rating of Health Plan	40.7%	60.8%	2.10	2.42	★★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table C-6 shows substantial increases in the rates for all four measures, for which **GLH** should be commended. Furthermore, three of the four measures were above the national Medicaid 75th percentile. Although Rating of Personal Doctor increased by more than 10 percentage points, the measure could still be considered the highest-priority opportunity for improvement due to its score being about average from a national perspective.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

GLH's FY 2005 on-site review results showed both performance strengths and opportunities for improvement to achieve full compliance with the requirements of the Medicaid managed care contract. The plan's strengths were in the core areas of Member, Quality Assurance/Utilization Review and MIS/Data Reporting/Claims Processing. The results indicated that **GLH** demonstrated compliance with criteria related to the content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; information system requirements; financial and administrative reporting to MDCH; timeliness of payments; and management of enrollment data. **GLH** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Administrative, Provider, and Fraud and Abuse. **GLH**'s plans were deemed acceptable by MDCH in terms of scope, content, and established timeline, with two exceptions indicated below. The action plan submitted to MDCH required that the plan:

- Ensure that the Board of Directors meets at least quarterly. Board member minutes reviewed as part of the August 2005 on-site visit indicated that **GLH**'s governing body had met quarterly since the previous on-site review.
- Follow the policy that the Department of Management and Budget (DMB) and MDCH be notified at least 21 days prior to the effective date of any subsequent changes in any subcontracts for administrative or management (non-health care) functions. The August 2005 on-site review indicated that **GLH** identifies subcontracts and/or delegation agreements that cover administrative or management functions, as required.
- Develop a plan using the prior authorization (PA) process to identify potential fraud and abuse by providers. It was suggested that **GLH** develop a PA log so that both PA approvals and denials can be noted in the meeting minutes of the Compliance and Peer Review committees and in credentialing files, etc., and MDCH/PIS should be notified. For the August 2005 on-site review, **GLH** submitted an outpatient PA log and indicated that a drill-down of services is performed and reviewed to detect potential fraud and abuse.
- Review the grievance log and the member service inquiries/complaints with a focus on identifying provider fraud and abuse. If fraud and abuse are identified, this should be noted in the meeting minutes of the Compliance and Peer Review committees and in credentialing files, etc., and MDCH/PIS should be notified. This corrective action was deemed unacceptable as submitted because **GLH**'s response included comments on detecting both member fraud and abuse and provider fraud and abuse, while the criteria under review (6.4.4 and 6.4.5) focused solely on detection of fraud and abuse by the provider. The August 2005 on-site review found that **GLH** was still in the process of developing reports for member and provider complaints. **GLH** plans to develop a report that can be sorted by both provider and member to aid in the detection of member and/or provider fraud and abuse.
- Review submitted medical claims and member service inquires/complaints with a focus on identifying member fraud and abuse. If fraud and abuse are identified, this should be noted in

the meeting minutes of the Compliance and Peer Review committees and in credentialing files, etc., and MDCH/PIS should be notified. This corrective action was deemed unacceptable because **GLH** did not discuss tasks that would be used to detect fraud and abuse by members, specifically through the review of submitted claims (medical and pharmacy) and review of member service inquiries/complaints. The August 2005 on-site review found evidence that **GLH** used medical and pharmacy claims to detect fraud and abuse by members.

Performance Measures

In FY 2005, it was recommended that **GLH** continue to focus on appropriate coding practices and explore methods to expand efforts to increase the actual well-child visit rates. The August 2005 on-site visit found that **GLH** did not meet the standards for Childhood Immunization (Combo 1 and 2), Well-Child Visits (0 to 15 months and 3 to 6 years), and Blood Lead Screening. **GLH** was required to develop and implement an improvement plan to address these areas.

An additional recommendation from FY 2005 was that **GLH** consider expanding the outreach and educational activities for its pregnant members and form a task group to further explore the issues with Postpartum Care in the population. The August 2005 on-site visit found that **GLH** did not meet the standard for Prenatal Care and the plan was required to develop and implement an improvement plan to address this area.

In FY 2005, it was also recommended that **GLH** expand its distribution of, and education about, clinical practice guidelines for chronic conditions and explore the potential of feedback to providers regarding specific guideline compliance rates. **GLH**'s 2006 QI Program Description stated that **GLH** is a member of the Michigan QI Consortium (MQIC), a group of health plans collaborating to establish and implement common clinical practice guidelines.

Performance Improvement Projects (PIPs)

GLH showed opportunities for improvement in its 2004-2005 Adolescent Immunization PIP in Activity 6, Element 10, "Data collection process;" and Activity 6, Element 11, "Data completeness." Although the topics differed, **GLH** showed improvement by including the data collection process in its 2005-2006 Blood Lead Testing PIP and showed partial improvement in data completeness. In 2004-2005, **GLH** did not provide the percentage of data completeness. For the 2005-2006 PIP, MDCH provided the data but **GLH** was responsible for rectifying its own data; consequently, this element received a *Partially Met* score.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

GLH's 2004 CAHPS results showed three global ratings and three composite scores that were below the national 25th percentile. The only areas that fell between the 25th and 50th percentiles were Rating of All Health Care and Getting Care Quickly. It was suggested that by taking action on opportunities identified from the HEDIS results, such as improving performance in women's preventive screenings and maternity services, higher CAHPS scores may result. In addition, it was recommended that **GLH** consider identifying and addressing the key drivers for targeted CAHPS measures. **GLH**'s 2005 CAHPS results showed improvement for the four overall ratings, with all four exceeding the 2005 NCQA national Medicaid CAHPS 50th percentiles.

Conclusions and Recommendations

The current review of **GLH** showed both strengths and opportunities for improvement. The results from the annual compliance review (with the noted exception of MIS/Data Reporting/Claims Processing) and from the CAHPS global ratings represented definite areas of strength for **GLH**, which were, or at least approached, best practices. MDCH might want to consider various methods to generalize the policies and practices at **GLH** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **GLH** should continue to improve the processes, procedures, and documentation for the MIS/Data Reporting/Claims Processing standard. Of the three elements not met within the scope of the review, two elements were within this standard.

From the assessment of the performance measures, five rates were above the national Medicaid HEDIS 2004 75th percentiles: Childhood and Adolescent Immunization Combo 2, Diabetes Care—LDL-C Level <130 and <100, and Asthma 18–56 Years. These measures represented relative areas of strength for **GLH**. Nonetheless, **GLH** should focus on three measures as opportunities for improvement due to scores that were below the 25th national HEDIS percentile: Appropriate Treatment for Children With URI, Controlling High Blood Pressure, and Asthma 10–17 Years. Furthermore, rates decreased for five additional measures between 2004 and 2005 (i.e., Diabetes Care—Eye Exam, Asthma—10–17 Years, Children's Access 7–11 Years, Adults' Access 20–44 Years, and Adults' Access 45–64 Years), also representing important opportunities for improvement.

The PIP scores indicated an additional opportunity for improvement. With an overall score of *Partially Met*, the PIP needs improvement within the following activities: study indicators, data collection, and real improvement achieved. The CMS protocol[C-1] would be helpful in furthering a better understanding of the underlying issues with those activities.

The assessment of the CAHPS scores points to the global measures for Rating of Specialist, Rating of All Health Care, and Rating of Health Plan as areas of strength. These measures scored above the national Medicaid 75th percentile. Nonetheless, the performance on the remaining measures was about average, from a national perspective, with the exception of How Well Doctors Communicate. That measure scored below the 25th national Medicaid percentile and should, therefore, become a higher priority opportunity for improvement than the other measures.

For the three domains of Quality, Timeliness, and Access, the averages for **GLH** approximated the statewide averages, demonstrating overall average performance. None of the differences between **GLH**'s scores and the statewide averages was substantively large. These findings indicated that **GLH** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

C-1 Conducting Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002).

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table D-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 5/5 represents five out of a total of five standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table D-1—HPM Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for HPM		State Average
	Number	Percent	
Administrative	5/5	100%	97.0%
Provider	7/7	100%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	4/5	80.0%	82.8%
MIS/Data Reporting/Claims Processing	3/3	100%	85.5%
Fraud and Abuse	10/11	90.9 %	86.1%

The table shows that **HPM** achieved perfect scores on four of the six categories of measures: Administrative, Provider, Member, and MIS/Data Reporting/Claims Processing. These areas were recognized strengths for **HPM** and may represent best practices.

The two scores below 100 percent were Quality/Utilization at 80.0 percent and Fraud and Abuse at 90.9 percent. Both categories of measures failed to achieve a perfect score by one element, meaning that 94.1 percent (i.e., 32/34 = .941) of the elements passed the review. These findings were evidence that the annual compliance review measures were an overall area of strength for **HPM,** with potential best practices that might be shared.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table D-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table D-2—HPM Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	68.5%	68.5%**	★★★
Adolescent Immunization Combo 2	31.9%	54.9%	★★★
Appropriate Treatment for Children With URI	79.8%	74.4%	★★
Breast Cancer Screening	60.0%	56.9%	★★
Cervical Cancer Screening	63.8%	61.6%	★★
Controlling High Blood Pressure	66.4%	61.2%	★★
Chlamydia Screening, 16–20 Years	44.6%	47.6%	★★
Chlamydia Screening, 21–26 Years	49.1%	52.2%	★★
Chlamydia Screening (Combined)	46.0%	49.9%	★★
Diabetes Care—HbA1c Testing	74.8%	79.2%	★★
Diabetes Care—Poor HbA1c Control*	46.1%	47.5%	★★
Diabetes Care—Eye Exam	57.6%	54.9%	★★★
Diabetes Care—LDL-C Screen	76.6%	85.4%	★★★
Diabetes Care—LDL-C Level <130	49.8%	47.7%	★★
Diabetes Care—LDL-C Level <100	29.4%	27.8%	★★
Diabetes Care—Nephropathy	44.2%	49.8%	★★
Asthma 5–9 Years	73.5%	67.7%	★★
Asthma 10–17 Years	60.3%	66.1%	★★
Asthma 18–56 Years	66.3%	70.7%	★★
Asthma Combined Rate	66.0%	68.5%	★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table D-2—HPM Scores for Performance Measures			
Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Medical Assistance With Smoking Cessation	65.4%	65.6%	★★
Well-Child 1st 15 Months, 0 Visits*	3.2%	2.0%	★★
Well-Child 1st 15 Months, 6+ Visits	62.0%	59.0%	★★★
Well-Child 3rd–6th Years of Life	59.5%	56.9%	★★
Adolescent Well-Care Visits	40.7%	41.2%	★★
Timeliness of Prenatal Care	74.6%	78.3%	★★
Postpartum Care	51.9%	57.4%	★★
Children's Access 12–24 Months	92.2%	93.9%	★★
Children's Access 25 Months–6 Years	82.2%	81.5%	★★
Children's Access 7–11 Years	82.5%	82.5%	★★
Adolescents' Access 12–19 Years	81.0%	82.4%	★★
Adults' Access 20–44 Years	79.5%	80.0%	★★
Adults' Access 45–64 Years	88.6%	88.0%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table D-2 shows that **HPM**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for six performance measures (i.e., Childhood and Adolescent Immunization Combo 2; Diabetes Care—Eye Exam and LDL-C Screen; Well-Child 1st 15 Months, 6+ Visits; and Adults' Access 45–64 Years). These measures represented relative areas of strength for **HPM**.

The table also shows that the rates for 27 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. None of the rates was below national Medicaid HEDIS 2004 25th percentiles, evidencing an area of relative strength for **HPM**.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, one measure was rotated from 2004 and, therefore, was not included in this evaluation. The rates improved or remained the same for 19 of the 32 (59.4 percent) nonrotated performance measures compared with the rates reported in 2004. The rate for Adolescent Immunization Combo 2 increased from 31.9 percent to 54.9 percent between the 2004 and 2005 assessments, indicating a substantive improvement. However, the rates decreased for 13 (40.6 percent) of the performance measures compared with 2004. Although none of the 2005 rates was below the 25th national Medicaid percentile, the finding that 13 of the rates declined between 2004 and 2005 suggested that several opportunities for improvement existed within the performance measures.

Validation of Performance Improvement Projects (PIPs)

HPM's results for the Blood Lead Testing PIP are presented in Table D-3 and Table D-4. Table D-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. Furthermore, **HPM** achieved a *Met* validation status with an overall score of 100 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table D-3—Overall PIP Scores *for* HPM	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**100%**
Validation Status	***Met***

Table D-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met*, *Partially Met*, *Not Met*, or scored as *NA*.

Table D-4—PIP Activity Scores *for* HPM					
Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I. Appropriate Study Topic	6	6	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1
IV. Correctly Identified Study Population	3	3	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0
VI. Accurate/Complete Data Collection	11	6	0	0	5
VII. Appropriate Improvement Strategies	4	4	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1
IX. Real Improvement Achieved	4	4	0	0	0
X. Sustained Improvement Achieved	1	1	0	0	0
Totals for all Activities	**53**	**46**	**0**	**0**	**7**

For the 53 PIP elements, 46 were *Met*, none was *Partially Met* or *Not Met*, and seven were *NA*. The findings indicated that **HPM** understood the PIP process and was able to conduct and produce a well-documented PIP, having achieved a score of *Met* on every applicable element within every activity.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **HPM**'s composite CAHPS scores are shown in Table D-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table D-5—HPM Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	61.5%	69.5%	2.43	2.57	★★
Getting Care Quickly	44.4%	44.2%	2.17	2.18	★★
How Well Doctors Communicate	53.2%	55.4%	2.33	2.39	★
Courteous and Helpful Office Staff	60.3%	64.4%	2.46	2.54	★★
Customer Service	NA	69.6%	NA	2.58	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that three of the four top box percentages reported in 2004 and 2005 showed improvement (Customer Service did not have a sufficient number of respondents for 2004). The fourth measure, Getting Care Quickly, fell by only 0.2 percentage points.

For 2005, the performance level was average for four of the five measures compared with national Medicaid percentiles. The fifth measure, How Well Doctors Communicate, was below the 25th national Medicaid percentile. These findings suggested that somewhat small improvements were made between 2004 and 2005, but that an opportunity for improvement still existed in all of the measures, especially How Well Doctors Communicate.

HPM's detailed scores for the global ratings are presented in Table D-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table D-6—HPM Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	51.6%	59.0%	2.31	2.43	★★
Rating of Specialist	59.9%	59.1%	2.45	2.44	★★
Rating of All Health Care	44.0%	51.4%	2.16	2.31	★★
Rating of Health Plan	33.0%	49.1%	1.98	2.25	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that three of the four measures improved from 2004 to 2005. Rating of Specialist fell by just 0.8 percentage points. The score for Rating of Health Plan increased by a substantively important amount. All four of the 2005 rates were about average from a national perspective. Comparatively, these average national ratings indicated continuing opportunities for improvement.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

HPM's FY 2005 on-site review results showed both performance strengths and opportunities for improvement. The plan's strengths were in the core areas of Administrative, Member, Quality Assurance/Utilization Review, and MIS/Data Reporting/Claims Processing. The results indicated that **HPM** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; information system requirements; financial and administrative reporting to MDCH; timeliness of payments; and management of enrollment data. **HPM** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider and Fraud and Abuse. **HPM**'s action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that the plan:

- Amend provider contracts to include reporting requirements for communicable diseases and other health indicators. At the May 2005 on-site visit, **HPM** demonstrated that it had amended its provider contract formats to satisfy this requirement.
- Amend the Oakland County Community Mental Health Agreement to include data reporting and quality assurance requirements. At the May 2005 on-site visit, **HPM** demonstrated that it had amended the agreement to incorporate these requirements and to meet the criteria.
- Revise the provider directory to include specialists' hospital affiliations and the addresses for smaller, independent pharmacies. At the May 2005 on-site visit, **HPM** demonstrated that it had amended its provider directory to meet the requirements of this criterion.
- Develop procedures to ensure **HPM**'s cooperation with MDCH in eliminating fraud and abuse. The May 2005 on-site visit found that **HPM** referred 11 suspected fraud and abuse cases to MDCH/PIS since the previous on-site visit.

One goal cited in **HPM**'s 2003 Quality Improvement Program Evaluation was to ensure that the plan's contracts with individual providers, including those making utilization management decisions, specify that contractors cooperate with **HPM**'s QI program. However, it was noted in 2004–2005 that opportunities for improvement continued to exist in this area. **HPM**'s 2006 QI Work Plan did not address this issue.

Performance Measures

In FY 2005, it was recommended that **HPM** consider increasing member and/or provider education regarding women's preventive and maternal care. **HPM**'s 2006 Quality Management (QM) Work Plan indicated that a women's health campaign began in January 2006.

Performance Improvement Projects (PIPs)

HPM showed opportunities for improvement in its 2004-2005 Blood Lead Testing PIP in Activity 6, Element 10, "Data collection process;" and Activity 6, Element 11, "Data completeness." Its 2005–2006 Blood Lead Testing PIP showed improvement in both areas. The data collection process and the percentage of data accuracy were included.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HPM's 2004 CAHPS results showed three global ratings and three composite scores that were below the national 25th percentile. The only areas that fell between the 25th and 50th percentiles were the Rating of Specialist and Getting Care Quickly. These results contrasted with **HPM**'s strong performance on the HEDIS Children's Care dimension and some of the components of the Living With Illness dimension. This suggested that while **HPM** has experienced some success in implementing processes that support quality, steps could be taken to improve members' experiences with respect to the care provided. It was suggested that **HPM** consider identifying and addressing the key drivers of the low CAHPS measure rates. **HPM**'s 2006 QM Work Plan includes as two of its goals ensuring QM assistance to provider services and member services to accomplish effective strategies for accessibility, program adequacy, and satisfaction for members and providers.

Conclusions and Recommendations

The current review of **HPM** showed both strengths and opportunities for improvement. The results from the annual compliance review and from the current PIP assessment represented definite areas of strength for **HPM** and were, or at least approached, best practices. MDCH might want to consider various methods to generalize the policies and practices at **HPM** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **HPM** should continue to work to improve Quality/Utilization processes, procedures, and documentation for the element that did not pass the review. Furthermore, **HPM** must provide the contact information and the address of the plan when discussing fraud and abuse information with employees. The remaining elements within the annual compliance review were all passed.

From the assessment of the performance measures, six rates were above the national Medicaid HEDIS 2004 75th percentiles: Childhood and Adolescent Immunization Combo 2; Diabetes Care—Eye Exam and LDL-C Screen; Well-Child 1st 15 Months, 6+ Visits; and Adults' Access 45–64 Years. These measures represented relative areas of strength for **HPM**. None of the rates was below the 25th national Medicaid percentiles. Nonetheless, rates for 13 measures declined between 2004 and 2005. **HPM** should focus on these 13 measures as opportunities for improvement.

PIPs were shown to be an area of strength. **HPM** scored 100 percent on all elements, evidencing an area of strength and potential best practices.

The assessment of the CAHPS scores suggested about average performance overall. Nonetheless, the How Well Doctors Communicate measure was seen as a higher-priority opportunity for improvement.

This measure scored below the 25th national Medicaid percentile. Furthermore, the two measures that declined between 2004 and 2005 were also recognized opportunities for improvement. These two measures were: Getting Care Quickly and Rating of Specialist.

For the domains of Quality, Timeliness, and Access, the averages for **HPM**, in general, approximated the statewide averages, indicating overall average performance. The one exception was the averages for annual compliance reviews, which outperformed the statewide averages in all three domains. None of the other differences between **HPM**'s scores and the statewide averages was substantively large. These findings indicated that **HPM** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table E-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 4/4 represents four out of a total of four standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table E-1—HPP Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for HPP		State Average
	Number	Percent	
Administrative	4/4	100%	97.0%
Provider	4/5	80.0%	88.5%
Member	5/5	100%	93.9%
Quality/Utilization	6/7	85.7%	82.8%
MIS/Data Reporting/Claims Processing	3/4	75.0%	85.5%
Fraud and Abuse	11/11	100%	86.1%

The table shows that **HPP** achieved perfect scores for three of the six categories under compliance review measures: Administrative, Member, and Fraud and Abuse. These three categories were recognized strengths for **HPP**. For the three remaining categories, Quality/Utilization achieved a somewhat higher score than the statewide average, while the scores for Provider and for MIS/Data Reporting/Claims Processing were somewhat lower. One element was not passed in each of the three categories, suggesting that a relatively modest effort by **HPP** could result in perfect scores in all six categories of the compliance review measures.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table E-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table E-2—HPP Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	76.6%	76.7%	★★★
Adolescent Immunization Combo 2	46.5%	64.0%	★★★
Appropriate Treatment for Children With URI	65.7%	71.3%	★
Breast Cancer Screening	67.0%	59.6%	★★
Cervical Cancer Screening	73.1%	70.4%	★★
Controlling High Blood Pressure	61.0%	65.8%	★★★
Chlamydia Screening, 16–20 Years	47.5%	45.6%	★★
Chlamydia Screening, 21–26 Years	56.2%	52.9%	★★
Chlamydia Screening (Combined)	52.2%	49.4%	★★
Diabetes Care—HbA1c Testing	83.9%	83.9%	★★★
Diabetes Care—Poor HbA1c Control*	36.7%	33.6%	★★★
Diabetes Care—Eye Exam	53.3%	57.4%	★★★
Diabetes Care—LDL-C Screen	84.4%	86.6%	★★★
Diabetes Care—LDL-C Level <130	50.6%	59.1%	★★★
Diabetes Care—LDL-C Level <100	26.5%	34.1%	★★★
Diabetes Care—Nephropathy	47.4%	56.4%	★★★
Asthma 5–9 Years	73.0%	75.0%	★★★
Asthma 10–17 Years	66.4%	69.3%	★★★
Asthma 18–56 Years	72.7%	75.3%	★★★
Asthma Combined Rate	70.8%	73.3%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table E-2—HPP Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Medical Assistance With Smoking Cessation	72.6%	73.1%	★★★
Well-Child 1st 15 Months, 0 Visits*	2.9%	2.9%**	★★
Well-Child 1st 15 Months, 6+ Visits	43.8%	43.8%**	★★
Well-Child 3rd–6th Years of Life	49.4%	57.2%	★★
Adolescent Well-Care Visits	32.6%	37.5%	★★
Timeliness of Prenatal Care	80.9%	82.9%	★★
Postpartum Care	61.2%	57.4%	★★
Children's Access 12–24 Months	94.2%	94.7%	★★
Children's Access 25 Months–6 Years	81.4%	80.8%	★★
Children's Access 7–11 Years	81.7%	81.8%	★★
Adolescents' Access 12–19 Years	82.2%	79.4%	★★
Adults' Access 20–44 Years	80.5%	82.0%	★★
Adults' Access 45–64 Years	89.7%	89.6%	★★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table E-2 shows that **HPP**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for 16 performance measures for 2005. These measures represented individual areas of strength for **HPP** and collectively suggested strong performance overall.

The table also shows that rates for 16 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Only one rate was below the national Medicaid HEDIS 2004 25th percentile, Appropriate Treatment for Children With URI. This measure represented a higher-priority opportunity for improvement for **HPP** versus any of the other measures when compared with national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, one measure was rotated from 2004 and, therefore, was not included in this evaluation. The rates improved or remained the same for 22 of the performance measures compared with rates reported in 2004. Notably, the rate for Adolescent Immunization Combo 2 increased from 46.5 percent in 2004 to 64.0 percent in 2005. The rates decreased for nine (29.0 percent) of the performance measures compared with 2004.

Validation of Performance Improvement Projects (PIPs)

HPP's results for the Blood Lead Testing PIP are presented in Table E-3 and Table E-4. Table E-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. **HPP** achieved a *Met* validation status with an overall score of 98 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table E-3—Overall PIP Scores *for* HPP	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**98%**
Validation Status	***Met***

Table E-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table E-4—PIP Activity Scores *for* HPP						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	4	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	7	0	1	1
IX.	Real Improvement Achieved	4	4	0	0	0
X.	Sustained Improvement Achieved	1	1	0	0	0
Totals for all Activities		**53**	**45**	**0**	**1**	**7**

For all 53 PIP elements evaluated, 45 were *Met*, zero were *Partially Met*, 1 was *Not Met*, and 7 were *NA*. The findings indicated that **HPP** understood the PIP process and was able to conduct and produce valid PIPs. Of the 46 scored elements (i.e., 53 total elements minus the seven that were *NA*), **HPP** scored a *Met* on all but one. An opportunity for improvement existed in Activity VIII, Sufficient Data Analysis and Interpretation.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **HPP**'s composite CAHPS scores are shown in Table E-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table E-5—HPP Detailed Results for CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	69.4%	77.1%	2.58	2.67	★★
Getting Care Quickly	41.9%	43.3%	2.10	2.14	★★
How Well Doctors Communicate	52.1%	59.9%	2.30	2.47	★★
Courteous and Helpful Office Staff	60.2%	67.0%	2.42	2.58	★★
Customer Service	NA	NA	NA	NA	NA

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that the four top box percentages reported in 2004 all showed improvement for 2005 (Customer Service did not have a sufficient number of respondents for 2004 or 2005). For 2005, the performance level was average for the four measures compared with the national Medicaid percentiles. These twin findings suggested that somewhat small improvements were made between 2004 and 2005, but an opportunity for improvement still existed in all four reported measures.

HPP's detailed scores for global ratings are presented in Table E-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table E-6—HPP Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	53.6%	55.1%	2.36	2.37	★★
Rating of Specialist	61.7%	62.0%	2.49	2.48	★★
Rating of All Health Care	46.8%	53.7%	2.23	2.34	★★
Rating of Health Plan	46.4%	50.8%	2.22	2.31	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all four measures improved from 2004 to 2005. Yet, the 2005 scores for all four measures were about average from a national perspective. This finding suggested opportunities for improvement for all four of the global ratings even though the improvements would be building on prior gains.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

HPP's December 2003 on-site review results reported in the FY 2005 contract year showed some performance strengths, specifically in the core areas of Administrative and Quality Assurance/Utilization Review. The results indicated that **HPP** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; and programs for individuals with special health care needs. A number of opportunities for improvement were noted for **HPP** to achieve full compliance with the requirements of the Medicaid managed care contract. **HPP** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider, Member, MIS/Data Reporting/Claims Processing, and Fraud and Abuse. The action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that the health plan:

- Develop, maintain, and follow a policy/process to notify the DMB and MDCH at least 21 days before the effective date of any subcontract or delegated agreement. The next on-site review, conducted in December 2004, found that **HPP** had developed a departmental procedure that addressed the purpose, procedure, and time frames to comply with the requirements of the MDCH/MHP contract.
- Continue to make an effort to contract with hospitals in Tuscola and Lapeer counties. The December 2004 on-site visit found that **HPP** had a contracted hospital in Tuscola County, but did not have a contracted hospital in Lapeer and Oakland counties.
- Obtain prior approval from MDCH for all written and oral materials provided to members. **HPP** demonstrated compliance with this criterion at the December 2004 on-site visit.
- Submit complete encounter data in a timely manner. At the December 2004 on-site visit, **HPP** provided MDCH performance monitoring reports as evidence that the information system supported encounter data tracking. **HPP** provided a screen print that showed the encounter data file was accepted.
- Develop, follow, and maintain a policy that ensures that 90 percent of all clean claims are paid within 30 days and 100 percent of all clean claims are paid within 45 days. Claims reports submitted to MDCH demonstrated that during November and December 2003, **HPP** did not process 90 percent of nonpharmacy claims within 30 days. In January and February 2004, **HPP** did not process 100 percent of nonpharmacy claims within 45 days, and **HPP**'s ending inventory of unprocessed claims more than 45 days old was greater than 2 percent. The December 2004 on-site review stated that **HPP** did not make timely payments to all providers for covered services rendered to enrollees in accordance with performance monitoring standards.
- Illustrate accountability to senior management, specifically, that the organizational chart indicates that the compliance officer has accountability to senior management. The December 2004 on-site review stated that **HPP** had a current organizational chart effective January 5,

2005, and that the position of compliance officer, with functional responsibilities as defined in the contract, was filled.

- Review the Excluded Parties Listing System (EPLS) when verifying provider credentials during the credentialing/recredentialing process. The December 2004 on-site review did not address this issue. **HPP**'s 2005 QI evaluation stated that the plan's credentialing and recredentialing processes conform to all applicable regulatory and accreditation requirements.

Performance Measures

The 2003 QI evaluation indicated extensive activities to reach noncompliant children (for well-child visits), including providing physician offices with letters and mailing labels. The evaluation did not indicate how many letters were sent out. This is an area that should be explored. It was recommended that **HPP** consider forming a multidisciplinary task force to examine the issue of noncompliance with well-child visits. **HPP**'s 2005 QI evaluation stated that well-child rates for all age bands were below **HPP**'s goals and NCQA benchmarks. A multidisciplinary group has identified specific barriers to receiving appropriate services and actions for improvement.

The Access to Care performance reported in FY 2005 was average compared with national benchmarks and in the top half of the Michigan MHPs. Although **HPP**'s mailings to noncompliant members appeared to be having some impact, it was recommended that this practice continue along with additional analyses to identify further barriers to care. **HPP**'s 2005 QI evaluation stated that the Access to Care rate for adults 20 to 44 years of age showed a statistically significant increase and was above the NCQA benchmark, but the rate was below the **HPP** goal. The rate for adults 45 to 64 years of age remained relatively unchanged and was near the **HPP** goal. A multidisciplinary group has identified specific barriers to appropriate care and identified actions for improvement.

Performance Improvement Projects (PIPs)

HPP had *Deemed* status and did not provide a PIP for validation in 2004-2005. There were, therefore, no prior-year recommendations for follow-up.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HPP's 2004 CAHPS results for the global Rating of Specialist fell between the 75th and 90th national NCQA percentiles. By contrast, one global rating (Personal Doctor) and three composite scores (Getting Care Quickly, How Well Doctors Communicate, and Courteous and Helpful Office Staff) were below the national 25th percentiles. The only areas that fell between the 25th and 50th percentiles were the overall Rating of All Health Care and Rating of Health Plan, and the Getting Needed Care composite measure. These results indicated an opportunity to focus efforts on improving members' experiences in all the dimensions of primary care evaluated by the CAHPS measures. It was recommended that **HPP** consider investigating whether there was a relationship between negative experiences with Personal Doctor, Getting Care Quickly, How Well Doctors Communicate, and Courteous and Helpful Office Staff and the difficulty achieving compliance with children's well-care visits. **HPP**'s 2005 QI evaluation stated that member satisfaction had notably

improved in the areas of overall Rating of Health Plan, Rating of All Health Care, Getting Needed Care, How Well Doctors Communicate, and Courteous and Helpful Office Staff. Member ratings of their personal doctor remained low.

Conclusions and Recommendations

The current review of **HPP** showed both strengths and opportunities for improvement. The results from the performance measures and from the current PIP assessment represented definite areas of strength for **HPP** and were, or at least approached, best practices. MDCH might want to consider various methods to generalize the policies and practices at **HPP** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **HPP** should continue to improve the performance for the element not passed in Provider, Quality/Utilization, and MIS/Data Reporting/Claims Processing. Nonetheless, of the 36 elements reviewed, **HPP** passed 33 (91.7 percent). This overall performance was a strength in **HPP**'s program.

From the assessment of the performance measures, 16 rates were above the national Medicaid HEDIS 2004 75th percentiles. These measures represented relative areas of strength for **HPP**. The only measure below the 25th national Medicaid percentile was Appropriate Treatment for Children With URI. This measure represented the most apparent opportunity for improvement within the performance measures. Additionally, the nine measures with rates that declined were also noted opportunities for improvement. Notably, however, the rate for Adolescent Immunization Combo 2 increased from 46.5 percent in 2004 to 64.0 percent in 2005.

PIPs were shown to be an area of strength. The only opportunity for improvement was in the data analysis and interpretation activity, where **HPP** did not meet the requirements of one of eight applicable elements within the activity.

The assessment of the CAHPS scores suggested about average performance for the measures overall and individually. All eight presented measures suggested that moderate improvements were made between 2004 and 2005, but that an opportunity for improvement still existed in all reported measures.

All of the averages for **HPP** within Quality, Timeliness, and Access were above the statewide averages except for the CAHPS measure within Quality and Timeliness. These findings indicated that **HPP** had a well-established QI program that met or exceeded the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table F-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 5/5 represents five out of a total of five standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table F-1—MCD Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for MCD		State Average
	Number	Percent	
Administrative	5/5	100%	97.0%
Provider	5/6	83.3%	88.5%
Member	4/4	100%	93.9%
Quality/Utilization	5/6	83.3%	82.8%
MIS/Data Reporting/Claims Processing	4/4	100%	85.5%
Fraud and Abuse	10/11	90.9%	86.1%

The table shows that **MCD**'s rates exceeded the statewide average for four of the categories of standards: Administrative, Member, Quality/Utilization, and MIS/Data Reporting/Claims Processing. These categories are apparent strengths for **MCD**.

The other two standards (i.e., Provider and Fraud and Abuse) appeared to show relative opportunities for improvement. Functionally, however, the opportunities for improvement were limited. For Provider, the **MCD** rate of 83.3 percent was functionally equivalent to the statewide average of 88.5 percent because there were only six elements to the standard, five of which were passed by **MCD**. To do any better, **MCD** would need to achieve a perfect score for the category. Functionally, the same situation existed for Fraud and Abuse.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table F-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table F-2—MCD Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	72.5%	72.5%**	★★★
Adolescent Immunization Combo 2	46.7%	46.7%**	★★★
Appropriate Treatment for Children With URI	90.4%	88.5%	★★★
Breast Cancer Screening	49.4%	47.2%	★
Cervical Cancer Screening	74.8%	73.8%	★★★
Controlling High Blood Pressure	71.1%	76.0%	★★★
Chlamydia Screening, 16–20 Years	52.0%	56.9%	★★★
Chlamydia Screening, 21–26 Years	58.7%	56.9%	★★★
Chlamydia Screening (Combined)	55.6%	56.9%	★★★
Diabetes Care—HbA1c Testing	89.4%	88.4%	★★★
Diabetes Care—Poor HbA1c Control*	37.8%	33.8%	★★★
Diabetes Care—Eye Exam	53.0%	55.1%	★★★
Diabetes Care—LDL-C Screen	87.1%	91.6%	★★★
Diabetes Care—LDL-C Level <130	58.1%	70.2%	★★★
Diabetes Care—LDL-C Level <100	37.8%	50.2%	★★★
Diabetes Care—Nephropathy	49.8%	60.0%	★★★
Asthma 5–9 Years	66.3%	77.6%	★★★
Asthma 10–17 Years	75.0%	75.0%	★★★
Asthma 18–56 Years	76.1%	69.6%	★★
Asthma Combined Rate	73.0%	73.6%	★★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table F-2—MCD Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Medical Assistance With Smoking Cessation	70.8%	74.3%	★★★
Well-Child 1st 15 Months, 0 Visits*	1.5%	1.5%**	★★
Well-Child 1st 15 Months, 6+ Visits	46.3%	46.3%**	★★
Well-Child 3rd–6th Years of Life	62.0%	62.0%**	★★
Adolescent Well-Care Visits	47.6%	47.6%**	★★★
Timeliness of Prenatal Care	80.0%	89.5%	★★★
Postpartum Care	52.7%	60.7%	★★
Children's Access 12–24 Months	97.3%	96.8%	★★★
Children's Access 25 Months–6 Years	86.2%	86.3%	★★
Children's Access 7–11 Years	86.8%	83.7%	★★
Adolescents' Access 12–19 Years	84.6%	81.5%	★★
Adults' Access 20–44 Years	80.2%	82.0%	★★
Adults' Access 45–64 Years	84.1%	85.5%	★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table F-2 shows that **MCD**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for 22 of 33 performance measures overall (i.e., 66.7 percent). These measures represented individual areas of strength for **MCD** and collectively suggest overall strong performance.

The table also shows that the rates for 10 of the 33 performance measures were about average (7 of the nonrotated measures), falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Only one rate was below national Medicaid HEDIS 2004 25th percentile, Breast Cancer Screening. This measure represented a higher-priority opportunity for improvement for **MCD** versus any of the other measures when compared with the national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, six measures were rotated from 2004 and, therefore, were not included in this evaluation. The rates improved or remained the same for 18 of the 27 (66.7 percent) nonrotated performance measures compared with rates reported in 2004. Notably, several of the measures substantively improved between 2004 and 2005. The rates decreased for nine (33.3 percent) of the performance measures compared with 2004. With Asthma 18–56 Years being a priority due to its substantively large decrease, these measures represent further opportunities for improvement.

Validation of Performance Improvement Projects (PIPs)

MCD's results for the Blood Lead Testing PIP are presented in Table F-3 and Table F-4. Table F-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. Furthermore, **MCD** achieved a *Met* validation status with an overall score of 100 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table F-3—Overall PIP Scores *for* MCD	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**100%**
Validation Status	***Met***

Table F-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table F-4—PIP Activity Scores *for* MCD						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	3	0	0	1
VIII.	Sufficient Data Analysis and Interpretation	9	9	0	0	0
IX.	Real Improvement Achieved	4	4	0	0	0
X.	Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities		**53**	**45**	**0**	**0**	**8**

For all 53 PIP elements (including critical elements) evaluated, 45 were *Met*, zero were *Partially Met*, zero were *Not Met*, and 8 were *Not Applicable*. The findings indicated that **MCD** understood the PIP process and was able to conduct and produce valid PIPs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **MCD**'s composite CAHPS scores are shown in Table F-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table F-5—MCD Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	72.8%	72.9%	2.62	2.63	★★
Getting Care Quickly	46.2%	42.5%	2.22	2.16	★★
How Well Doctors Communicate	58.9%	58.1%	2.47	2.45	★★
Courteous and Helpful Office Staff	65.5%	63.3%	2.55	2.54	★★
Customer Service	60.1%	62.4%	2.48	2.53	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that two of the five top box percentages and three-point means showed improvement for 2005. For 2005, the performance level was about average for all five measures compared with the national Medicaid percentiles. Overall, these results suggested important opportunities for improvement where the rates have decreased (i.e., Getting Care Quickly, How Well Doctors Communicate, and Courteous and Helpful Office Staff).

MCD's detailed scores for global ratings are presented in Table F-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table F-6—MCD Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	55.5%	56.2%	2.40	2.41	★★
Rating of Specialist	56.3%	49.1%	2.36	2.30	★
Rating of All Health Care	50.4%	52.1%	2.32	2.37	★★
Rating of Health Plan	48.5%	51.0%	2.26	2.36	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table F-6 shows increases for three of the four global rating measures. Nonetheless, the score for Rating of Specialist placed it below the 25th national percentile. This nationally low rating strongly suggested an important opportunity for improvement for **MCD**.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

MCD's July 2004 on-site review results showed both performance strengths and opportunities for improvement to achieve full compliance with the requirements of the Medicaid managed care contract. The plan's strengths were in the core areas of Administrative, Provider, Quality Assurance/Utilization Review and Fraud and Abuse. The results indicated that **MCD** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; subcontracted and delegated functions; provisions for the scope of covered services; primary care providers, network adequacy, and provider relations; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; fraud and abuse policies and procedures; risk management methodology; claims auditing processes; and utilization trending procedures. It was noteworthy that **MCD** was one of three MHPs to demonstrate compliance with all standards in the area of Fraud and Abuse. **MCD** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Member and MIS/Data Reporting/Claims Processing. The action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that **MCD**:

- Finalize a policy for reviewing the member handbook. The March 2005 on-site review stated that MDCH was currently reviewing **MCD**'s revised handbook, which was submitted in January 2005.
- Submit the provider directory and all member materials to MDCH for approval prior to member distribution. The March 2005 on-site review found that on December 6, 2004, **MCD** received MDCH approval for its provider directory.
- Submit all required reports on time and complete. The March 2005 on-site review found that **MCD** had submitted all reports by the required due date.
- Meet both standards of having 90 percent of clean claims paid in 30 days and less than 2 percent of inventory of unprocessed claims more than 45 days old. The March 2005 on-site review found that the monthly claims reports for the previous nine months indicated that more than 90 percent of clean nonpharmacy claims were processed within 30 days and all clean pharmacy claims were processed within 45 days. **MCD**'s ending inventory of unprocessed claims more than 45 days old was always less than the 2 percent allowed by MDCH.

MCD's evaluation of the 2002–2003 quality improvement program noted that the MHP had identified claims payment in a timely manner as an operational area for improvement in 1998 and had focused on improving timeliness and accuracy since that time. The 2003-2004 Implementation Plan indicated a goal of 98 percent timeliness in 30 days, and it was recommended in FY 2005 that continued attention should be focused on this area. The March 2005 on-site review stated that **MCD** had demonstrated that it made timely payments to all providers for authorized covered services.

Performance Measures

No recommendations were offered in 2004–2005. There were, therefore, no prior-year recommendations for follow-up.

Performance Improvement Projects (PIPs)

MCD had *Deemed* status and did not provide a PIP for validation in 2004-2005. There were, therefore, no prior-year recommendations for follow-up.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

MCD's 2004 CAHPS results for the composite scores for Getting Care Quickly and How Well Doctors Communicate fell between the 50th and 75th NCQA national percentiles. All other composite scores and global ratings were between the 25th and 50th percentiles except for Rating of Specialist, which fell below the 25th percentile. It was noted that these findings warranted focused attention on improving members' experiences with accessing and receiving care. However, **MCD**'s 2004–2005 QI evaluation indicated that 2005 CAHPS results were quite similar to the previous year's results.

Conclusions and Recommendations

The current review of **MCD** showed both strengths and opportunities for improvement, with strengths being predominant. The results from three of the four categories assessed (i.e., annual compliance review, performance measures, and PIP) supported the finding of relative strength for **MCD**, with results that were, or at least approached, best practices. MDCH might want to consider various methods to generalize the policies and practices at **MCD** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **MCD** should continue to improve performance on the element not passed in Provider, Quality/Utilization, and Fraud and Abuse. Nonetheless, of the 36 elements reviewed, **MCD** passed 33 (91.7 percent). This overall performance shows a strength to **MCD**'s program.

From the assessment of the Performance Measures, 22 rates were above the national Medicaid HEDIS 2004 75th percentiles. Notably, several of the measures substantively improved between 2004 and 2005. These measures represented relative areas of strength for **MCD**. The only measure below the 25th national Medicaid percentile was Breast Cancer Screening. This measure represented the most apparent opportunity for improvement within the performance measures. Additionally, the nine measures with rates that declined were also noted opportunities for improvement, especially Asthma 18–56 Years, due to its substantively large decrease. Lastly, **MCD** might want to target the measures that scored at an average level from a national perspective.

PIPs were shown to be an area of strength. **MCD** scored 100 percent on all elements, evidencing an area of strength and potential best practices.

The assessment of the CAHPS scores suggested mostly average performance overall. Rating of Specialist scored below the 25th national percentile and should be a high-priority opportunity for improvement for **MCD**.

MCD's averages for all of the individual categories within Quality, Timeliness, and Access were above the statewide averages except for the CAHPS measures within Quality and Timeliness. From this perspective, **MCD** showed itself to be one of the higher-performing MHPs in the State. These findings indicated that **MCD** had a well-established QI program that met or exceeded the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table G-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 6/6 represents six out of a total of six standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table G-1—MCL Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for MCL		State Average
	Number	Percent	
Administrative	6/6	100%	97.0%
Provider	6/7	85.7%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	4/5	80.0%	82.8%
MIS/Data Reporting/Claims Processing	4/4	100%	85.5%
Fraud and Abuse	8/11	72.7%	86.1%

The table shows that **MCL**'s rates exceeded the statewide average for three of the six categories of standards: Administrative, Member, and MIS/Data Reporting/Claims Processing. These categories were apparent strengths for **MCL**.

The other three standards (i.e., Provider, Quality/Utilization, and Fraud and Abuse) appeared to show relative opportunities for improvement. Functionally, however, opportunities for improvement were limited for Provider and Quality/Utilization. For Provider, the **MCL** rate of 85.7 percent was functionally equivalent to the statewide average of 88.5 percent because there were only seven elements to the standard, six of which were passed by **MCL**. To do any better, **MCL** would need to achieve a perfect score for the category. Functionally, the same situation existed for Quality/Utilization.

Fraud and Abuse presented a larger opportunity for improvement than the other categories for two reasons. First, the rate was substantively lower than the other **MCL** rates. Second, **MCL**'s rate of 72.7 percent was substantively lower than the statewide average rate of 86.1 percent. Unlike Provider and Quality/Utilization, which had rates that were a bit lower than the statewide averages but were functionally equivalent, **MCL** could have passed more elements within Fraud and Abuse without also needing to achieve a perfect score. **MCL** could have passed an additional element and still been a bit lower than the statewide average. Furthermore, passing a second additional element (i.e., 10 of 11) would still not have required a perfect score.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table G-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table G-2—MCL Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	67.9%	73.7%	★★★
Adolescent Immunization Combo 2	34.3%	46.7%	★★★
Appropriate Treatment for Children With URI	67.8%	64.8%	★
Breast Cancer Screening	62.2%	57.8%	★★
Cervical Cancer Screening	66.9%	67.9%	★★
Controlling High Blood Pressure	72.5%	59.6%	★★
Chlamydia Screening, 16–20 Years	51.5%	48.4%	★★
Chlamydia Screening, 21–26 Years	54.5%	52.3%	★★
Chlamydia Screening (Combined)	53.0%	50.4%	★★
Diabetes Care—HbA1c Testing	79.4%	79.3%	★★
Diabetes Care—Poor HbA1c Control*	43.1%	41.1%	★★
Diabetes Care—Eye Exam	48.9%	51.6%	★★
Diabetes Care—LDL-C Screen	74.9%	75.4%	★★
Diabetes Care—LDL-C Level <130	51.3%	53.5%	★★
Diabetes Care—LDL-C Level <100	28.6%	31.1%	★★
Diabetes Care—Nephropathy	52.4%	52.8%	★★
Asthma 5–9 Years	64.3%	82.9%	★★★
Asthma 10–17 Years	69.4%	71.9%	★★★
Asthma 18–56 Years	66.9%	75.7%	★★★
Asthma Combined Rate	66.9%	76.5%	★★★
Medical Assistance With Smoking Cessation	66.7%	69.4%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table G-2—MCL Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Well-Child 1st 15 Months, 0 Visits*	2.2%	2.2%	★★
Well-Child 1st 15 Months, 6+ Visits	48.4%	45.4%	★★
Well-Child 3rd–6th Years of Life	50.4%	51.6%	★
Adolescent Well-Care Visits	44.3%	36.7%	★★
Timeliness of Prenatal Care	79.7%	88.1%	★★★
Postpartum Care	54.7%	65.5%	★★★
Children's Access 12–24 Months	91.7%	93.9%	★★
Children's Access 25 Months–6 Years	78.5%	79.2%	★★
Children's Access 7–11 Years	79.4%	80.0%	★★
Adolescents' Access 12–19 Years	75.5%	76.5%	★★
Adults' Access 20–44 Years	79.7%	80.4%	★★
Adults' Access 45–64 Years	87.8%	88.0%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table G-2 shows that **MCL**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for 10 performance measures. These measures represented individual areas of strength for **MCL**.

The table also shows that rates for 21 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Two of the 2005 rates were below national Medicaid HEDIS 2004 25th percentiles: Appropriate Treatment for Children With URI and Well-Child 3rd–6th Years of Life. These measures represented higher-priority opportunities for improvement for **MCL** versus the other measures when compared with the national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. The rates improved or remained the same for 24 of the 33 (72.7 percent) performance measures compared with rates reported in 2004. The rates decreased for 9 (27.3 percent) of the performance measures compared with 2004, indicating additional opportunities for improvement. Notably, however, the rate for Asthma 5–9 Years increased from 64.3 percent in 2004 to 82.9 percent in 2005.

Validation of Performance Improvement Projects (PIPs)

MCL's results for the Blood Lead Testing PIP are presented in Table G-3 and Table G-4. Table G-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. Furthermore, **MCL** achieved a *Met* validation status with an overall score of 100 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table G-3—Overall PIP Scores *for* MCL	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**100%**
Validation Status	***Met***

Table G-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met*, *Partially Met*, *Not Met*, or scored as *NA*.

Table G-4—PIP Activity Scores *for* MCL					
Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I. Appropriate Study Topic	6	6	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1
IV. Correctly Identified Study Population	3	3	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0
VI. Accurate/Complete Data Collection	11	6	0	0	5
VII. Appropriate Improvement Strategies	4	4	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	9	0	0	0
IX. Real Improvement Achieved	4	3	0	0	1
X. Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities	**53**	**45**	**0**	**0**	**8**

For all 53 PIP elements (including critical elements) evaluated, 45 were *Met*, zero were *Partially Met*, zero were *Not Met*, and 8 were *NA*. The findings indicated that **MCL** understood the PIP process and was able to conduct and produce valid PIPs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **MCL**'s composite CAHPS scores are shown in Table G-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table G-5—MCL Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	72.1%	71.6%	2.61	2.59	★★
Getting Care Quickly	46.6%	49.3%	2.24	2.25	★★★
How Well Doctors Communicate	60.7%	62.1%	2.47	2.50	★★
Courteous and Helpful Office Staff	66.3%	68.2%	2.55	2.58	★★
Customer Service	NA	69.6%	NA	2.61	★★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that three of the four top box percentages and three-point means reported in 2004 showed improvement for 2005. Customer Service did not have a sufficient number of respondents for 2004 and performance on Getting Needed Care slightly declined. For 2005, the performance level was above average for two measures and about average for three measures compared with national Medicaid percentiles. **MCL** should consider the measures at the average performance level as opportunities for improvement.

MCL's detailed scores for global ratings are presented in Table G-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table G-6—MCL Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	61.6%	55.7%	2.48	2.43	★★
Rating of Specialist	62.9%	57.1%	2.49	2.38	★
Rating of All Health Care	55.0%	51.6%	2.38	2.34	★★
Rating of Health Plan	47.8%	50.0%	2.25	2.30	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that the rates for Rating of Personal Doctor, Rating of Specialist, and Rating of All Health Care declined in 2005 compared with 2004. Yet, the results for Rating of Health Plan showed a small increase. This apparent contradiction might be explained by the improvement seen in the composite scores from Table G-5.

The table also shows that three of the four rates for 2005 were about average from a national perspective. The result for Rating of Specialist was below the 25th national Medicaid percentile. Combined, these results suggested that credit for the increases should be given to the composite scores, but the characteristics reflected by the three global ratings that declined presented continued opportunities for improvement, especially Rating of Specialist.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

MCL's on-site review results reported in FY 2005 showed both performance strengths and opportunities for improvement. The plan's strengths were in the core areas of Administrative, Quality Assurance/Utilization Review and MIS/Data Reporting/Claims Processing. The results indicated that **MCL** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; information system requirements; financial and administrative reporting to MDCH; timeliness of payments; and management of enrollment data. **MCL** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider, Member, and Fraud and Abuse. It was noteworthy that **MCL** did not receive a passing score for three criteria in Fraud and Abuse, a relatively high number in comparison to other MHP results. **MCL**'s action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that **MCL**:

- Continue its efforts to obtain contracted hospitals in all Medicaid service areas in which a hospital was located. **MCL** must demonstrate that covered services are available and accessible and are located within 30 minutes/miles of members. The September 2005 on-site review found that **MCL** had continued its efforts to obtain contracts with hospitals located in its Medicaid service area and had been successful in obtaining a contract with a hospital located in Arenac County.
- Revise its automated voice mail message to provide information for members to access after-hours urgent and/or emergency care. This was not addressed in the September 2005 on-site review report.
- Develop a policy stating that **MCL** has procedures to ensure the plan's cooperation with MDCH to eliminate fraud and abuse or include this in an already existing policy. The September 2005 on-site review stated that **MCL** submitted reports as evidence that the plan has in effect mechanisms for and demonstrates the use of a process to detect both under- and overutilization of services, and uses this information to identify potential fraud and abuse.
- Begin reviewing submitted claims (medical and pharmacy), the prior authorization log (approvals and denials), the grievance log, member service inquiries/complaints, and medical record review to detect fraud and abuse by providers. If fraud or abuse is noted, **MCL**'s committee meeting minutes should reflect discussion of the provider's issue(s) and any corrective action instituted. **MCL** should notify MDCH/PIS of any instance of provider fraud or abuse. The September 2005 on-site review indicated that such activities were implemented.
- Begin reviewing submitted medical claims to detect fraud and abuse by members. The September 2005 on-site review indicated that such activities were implemented.

Performance Measures

The 2004 QI program indicated the use of reminder cards and some proactive calling. It was suggested that **MCL** augment these activities with targeted reminders to noncompliant members and furnish providers with their individual compliance rates and noncompliant member rosters. **MCL**'s 2005 QI evaluation stated that ongoing efforts to connect with at-risk membership remained a priority in 2005.

It was recommended in FY 2005 that **MCL** continue its efforts to identify pregnant members as early as possible in order to enroll them in the Early Care Healthy Families Program. **MCL**'s 2005 QI evaluation stated that the plan enrolled more than 1,200 pregnant members, with 72 percent being contacted before delivery. HEDIS measures for prenatal and postpartum care increased significantly.

It was also recommended in FY 2005 that **MCL** reevaluate the diabetes disease management program, reviewing the process for participation to ensure that all eligible diabetics are informed of the program and offered an opportunity to participate. **MCL**'s 2005 QI evaluation noted that the plan had increased the number of members in disease management programs by more than 20 percent. In the asthma and diabetes programs, more than 51 percent of the enrolled members were in case management. New initiatives in 2005 included a "diabetic blitz" program in the fourth quarter that entailed contacting members regarding core measures.

Performance Improvement Projects (PIPs)

MCL had *Deemed* status and did not provide a PIP for validation in 2004-2005. There were, therefore, no prior-year recommendations for follow-up.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

MCL's 2004 CAHPS results showed that one global rating, Rating of Specialist, and one composite score, Getting Care Quickly, fell between the NCQA national 75th and 90th percentiles. Four areas fell between the 50th and 75th percentiles: the global Rating of Personal Doctor and Rating of All Health Care, and composite scores for Getting Needed Care and How Well Doctors Communicate. The remaining areas fell between the 25th and 50th percentiles. **MCL**'s relatively strong performance on the CAHPS measures suggested that the basics of providing quality service to members were in place and could be used to support QI efforts stemming from the HEDIS results. **MCL**'s 2005 QI evaluation stated that the plan had more than 40 outreach programs focusing on preventive care. The evaluation further stated that collaboratively, member services and medical management have championed this area, and the increase in HEDIS and State performance rates validated these programs.

Conclusions and Recommendations

The current review of **MCL** showed both strengths and opportunities for improvement, with strengths being predominant. The results from previously highlighted measures from the annual compliance review, performance measures, PIP, and CAHPS support the finding of relative strength for **MCL**, at or approaching best practices. MDCH might want to consider various methods to generalize the policies and practices at **MCL** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **MCL** should continue to improve performance on the element not passed in Provider, Quality/Utilization, and Fraud and Abuse. Nonetheless, of the 36 elements reviewed, **MCL** passed 31 (86.1 percent).

From the assessment of the performance measures, 10 rates were above the national Medicaid HEDIS 2004 75th percentiles. These measures represented relative areas of strength for **MCL**. The two measures below the 25th national Medicaid percentiles were Appropriate Treatment for Children With URI and Well-Child 3rd–6th Years of Life. These measures represented the most apparent opportunities for improvement within the performance measures. Additionally, the nine measures with rates that declined were also noted opportunities for improvement. Lastly, **MCL** might want to target the measures that scored at an average level from a national perspective.

PIPs were shown to be an area of strength. **MCL** scored 100 percent on all elements, evidencing an area of strength and potential best practices.

The assessment of the CAHPS scores suggested mixed performance overall. **MCL** showed higher relative scores and improvements for the composite measures than for the global measures. For the composite measures, Getting Needed Care, How Well Doctors Communicate, and Courteous and Helpful Office Staff remained continuing opportunities for improvement.

For the global measures, only Rating of Health Plan increased, and it did so by only 2.2 percentage points. The remaining three global measures were continuing opportunities for improvement, especially Rating of Specialist, with a score that was below the 25th national Medicaid percentile.

For the domains of Quality, Timeliness, and Access, the averages for **MCL** were similar to the statewide averages, indicating overall average performance. None of the differences between **MCL**'s scores and the statewide averages was substantively large. These findings indicated that **MCL** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table H-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 3/3 represents three out of a total of three standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table H-1—MID Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for MID		State Average
	Number	Percent	
Administrative	3/3	100%	97.0%
Provider	6/6	100%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	3/4	75.0%	82.8%
MIS/Data Reporting/Claims Processing	4/4	100%	85.5%
Fraud and Abuse	9/11	81.8%	86.1%

The table shows that **MID** achieved perfect scores on four of the six categories of measures: Administrative, Provider, Member, MIS/Data Reporting/Claims Processing. These areas were recognized strengths for **MID** and may represent best practices.

The two scores below 100 percent were Quality/Utilization at 75.0 percent and Fraud and Abuse at 81.8 percent. The scoring for the individual elements for Quality/Utilization showed that **MID** missed only one element. The situation for Fraud and Abuse, however, was somewhat different. **MID** passed 9 of the 11 elements in the category. For this reason, elements in Fraud and Abuse that were not passed were opportunities for improvement. Quality/Utilization presented a smaller, but still important, opportunity for improvement for the element that was not passed.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and to determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table H-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table H-2—MID Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	62.0%	72.0%	★★★
Adolescent Immunization Combo 2	24.6%	51.8%	★★★
Appropriate Treatment for Children With URI	75.5%	75.7%	★★
Breast Cancer Screening	51.3%	49.6%	★
Cervical Cancer Screening	50.9%	58.9%	★★
Controlling High Blood Pressure	54.8%	56.7%	★★
Chlamydia Screening, 16–20 Years	31.9%	32.1%	★
Chlamydia Screening, 21–26 Years	37.6%	37.8%	★★
Chlamydia Screening (Combined)	34.5%	34.8%	★
Diabetes Care—HbA1c Testing	59.6%	71.5%	★★
Diabetes Care—Poor HbA1c Control*	67.4%	47.7%	★★
Diabetes Care—Eye Exam	32.4%	44.3%	★★
Diabetes Care—LDL-C Screen	64.5%	79.8%	★★
Diabetes Care—LDL-C Level <130	53.3%	62.8%	★★★
Diabetes Care—LDL-C Level <100	46.7%	40.1%	★★★
Diabetes Care—Nephropathy	35.8%	43.6%	★★
Asthma 5–9 Years	51.5%	52.9%	★
Asthma 10–17 Years	54.7%	56.3%	★
Asthma 18–56 Years	66.6%	67.0%	★★
Asthma Combined Rate	60.7%	61.3%	★★
Medical Assistance With Smoking Cessation	60.4%	63.3%	★★
Well-Child 1st 15 Months, 0 Visits*	5.1%	5.0%	★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table H-2—MID Scores for Performance Measures			
Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Well-Child 1st 15 Months, 6+ Visits	44.8%	46.1%	★★
Well-Child 3rd–6th Years of Life	56.2%	65.9%	★★
Adolescent Well-Care Visits	30.9%	48.4%	★★★
Timeliness of Prenatal Care	53.1%	66.7%	★
Postpartum Care	38.2%	41.8%	★
Children's Access 12–24 Months	89.5%	91.2%	★★
Children's Access 25 Months–6 Years	76.5%	79.2%	★★
Children's Access 7–11 Years	79.7%	80.9%	★★
Adolescents' Access 12–19 Years	75.0%	78.4%	★★
Adults' Access 20–44 Years	74.2%	72.6%	★★
Adults' Access 45–64 Years	82.5%	82.6%	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table H-2 shows that **MID**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for five performance measures (Childhood and Adolescent Immunization Combo 2, Diabetes Care—LDL-C Level <130 and <100, and Adolescent Well-Care Visits). Notably, Adolescent Immunization Combo 2 increased from 24.6 percent to 51.8 percent. These five measures represented relative areas of strength for **MID**, assessed through national comparisons.

The table also shows that rates for 20 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Eight rates were below national Medicaid HEDIS 2004 25th percentiles. These rates were: Breast Cancer Screening; Chlamydia Screening, 16–20 Years and Combined; Asthma 5–9 Years and 10–17 Years; Well-Child 1st 15 Months, 0 Visits; Timeliness of Prenatal Care; and Postpartum Care. These measures represented relative opportunities for improvement for **MID** compared with national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. Rates improved for 30 of the 33 (90.9 percent) performance measures compared with rates reported in 2004. This high performance for the percentage of improving rates suggested a strong quality improvement principle at **MID**.

The rates decreased for only three (9.1 percent) of the performance measures compared with 2004: Breast Cancer Screening, Diabetes Care—LDL-C Level <100, and Adults' Access 20–44 Years. A comparison with national performance levels suggested that the three measures be prioritized as opportunities for improvement as follows: Breast Cancer Screening (due to its low performance relative to national levels), Adults' Access 20–44 Years (due to its average performance), and then Diabetes Care—LDL-C Level <100 (which still had above-average current performance).

Validation of Performance Improvement Projects (PIPs)

MID's results for the Blood Lead Testing PIP are presented in Table H-3 and Table H-4. Table H-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. Furthermore, **MID** achieved a *Met* validation status with an overall score of 100 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table H-3—Overall PIP Scores *for* MID	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**100%**
Validation Status	***Met***

Table H-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table H-4—PIP Activity Scores *for* MID						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	2	0	0	2
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	0	1
IX.	Real Improvement Achieved	4	4	0	0	0
X.	Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities		**53**	**43**	**0**	**0**	**10**

For all 53 PIP elements (including critical elements) evaluated, 43 were *Met*, zero were *Partially Met*, zero were *Not Met*, and 10 were *NA*. The findings indicated that **MID** understood the PIP process and was able to conduct and produce valid PIPs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **MID**'s composite CAHPS scores are shown in Table H-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table H-5—MID Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	64.6%	69.4%	2.51	2.55	★★
Getting Care Quickly	41.3%	48.0%	2.10	2.18	★★
How Well Doctors Communicate	59.8%	60.7%	2.46	2.43	★★
Courteous and Helpful Office Staff	59.7%	65.4%	2.45	2.49	★
Customer Service	NA	68.0%	NA	2.59	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all four top box percentages reported in 2004 and 2005 showed improvement (Customer Service did not have a sufficient number of respondents for 2004). This improvement needs to continue, starting with Courteous and Helpful Office Staff because it scored lower than the 25th national Medicaid percentile. The other four measures represented continued opportunities for improvement because they scored about average relative to the national Medicaid percentiles.

MID's detailed scores for global ratings are presented in Table H-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table H-6—MID Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	52.9%	56.7%	2.37	2.42	★★
Rating of Specialist	53.7%	65.4%	2.35	2.48	★★
Rating of All Health Care	48.8%	54.6%	2.31	2.35	★★
Rating of Health Plan	44.8%	53.4%	2.20	2.35	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all four measures improved from 2004 to 2005, a recognized strength for **MID**. Yet, the 2005 scores for all four measures were about average from a national perspective. This finding suggested opportunities for improvement for all four of the global ratings. Importantly, gains on some of these measures would be building on substantively large prior gains, such as Rating of Specialist, which increased from 53.7 percent in 2004 to 65.4 percent in 2005.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

MID's 2004 on-site review results showed performance strength in the Administrative core area. The results indicated that **MID** demonstrated compliance with criteria related to the structure of the organization and the composition, function, and activities of the governing body. A number of opportunities for improvement existed for **MID** to achieve full compliance with the requirements of the Medicaid managed care contract. It was noteworthy that **MID** was the only MHP to receive *Incomplete* scores in five of the six core areas. The plan also received one of the highest number of *Incomplete* scores overall. **MID** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider, Member, Quality Assurance/Utilization Review, MIS/Data Reporting/Claims Processing, and Fraud and Abuse. The action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that the plan must:

- Revise the provider network directory to include all required information—specifically, specialists' hospital affiliations—and revise the narrative to meet the sixth-grade reading level requirement. **MID** must obtain MDCH approval prior to publication. The September 2005 on-site review found that **MID** had improved the provider directory, categorizing each county in its approved service area. The directory was updated and approved on September 9, 2005, and includes hospital affiliations for specialists.
- Correct its provider manual to reflect additional appeal processes involving **MID**—specifically, describe the provider's right to binding arbitration or rapid dispute resolution. **MID** should eliminate the reference to contacting MDCH. The September 2005 on-site review report indicated that this had been addressed.
- Revise its policy and procedure to include acknowledgment of member grievances and appeals. **MID** must provide written acknowledgment to members and notify members that they must file an appeal to MDCH within 90 days of receipt of **MID**'s decision. At the September 2005 on-site review, **MID** provided copies of the 2004 and 2005 grievance logs and the letter that is sent when a complaint is received.
- Follow the procedures outlined in the plan's policy, specifically with respect to providing an Inter-Rater Reliability Review Report regarding the PA and referral process. At the September 2005 on-site review, **MID** provided a copy of the Inter-Rater Reliability Review Report for 2004.
- Process 90 percent of clean claims within 30 days and maintain an inventory with less than 2 percent of claims more than 45 days old. The September 2005 on-site review found that **MID** makes timely payments to all providers for covered services rendered to enrollees. More than 90 percent of clean claims were processed within 30–45 days of receipt, averaging 96 percent from August 2004 to July 2005. **MID**'s inventory of claims more than 45 days old was 0 percent for the entire year.
- Use the definitions of fraud and abuse as stated in 42 CFR 455.2. The September 2005 on-site review found that **MID** had addressed this issue.

- Begin using or adapt current processes that use the pharmacy claims, provider profiling, and PA reports (approvals and denials) to detect fraud and abuse by providers. The September 2005 on-site review found that **MID** had addressed this issue.
- Review pharmacy claims to detect fraud and abuse by members. The primary care providers (PCPs) may continue to review the pharmacy claims as an adjunct to **MID**'s review. The September 2005 on-site review found that **MID** had addressed this issue.

MID's 2004 QI Work Plan described QI development activities, i.e., new requirements or new processes. Continuing a process for the monitoring of sanctions or complaints about network practitioners was noted as an ongoing activity initiated prior to 2001. Further, the 2004 QI Work Plan indicated that claims timeliness was a key performance indicator, with a goal of 30 calendar days, to be reported monthly. Opportunities for improvement continued to exist in these areas, as determined during the 2004 on-site review conducted by MDCH. The 2005 on-site review indicated improvements in this area.

Performance Measures

In FY 2005, it was suggested that **MID** consider personalized reminder cards to parents for children needing immunizations. Similarly, well-child visit rates might increase if the high-risk program was expanded to all children and incorporated personalized reminder cards to a parent/caregiver of noncompliant children. **MID**'s 2005 QI evaluation stated that the plan had an incentive program in place for members and provider office staff, resulting in a steady increase in the number of children who completed all recommended immunizations by 2 years of age and 13 years of age.

It was recommended that **MID** also consider sending lists of noncompliant children and postpartum women to PCPs on a cyclical basis. Many health plans have been able to increase prenatal and postpartum performance rates by expanding their high-risk programs to the entire population. Different risk levels receive different interventions, but all receive targeted reminder cards and providers are given lists of noncompliant patients. **MID**'s 2005 QI evaluation stated that in 2005, 92 women were referred for enrollment in the Rosebud Prenatal/Neonatal Management Program. Of these, 19 were enrolled in the low-risk program and 12 were determined to be at high risk and enrolled in case management.

It was noted that both the asthma and diabetes programs would benefit from personalized reminders to noncompliant patients and lists of noncompliant patients sent to providers. **MID**'s 2005 QI evaluation stated that a more comprehensive program of mailings to members with diabetes would be reactivated in January 2006. Members with asthma received educational mailings at least twice per year, and those identified as high-risk or in need received additional clinical interventions.

Performance Improvement Projects (PIPs)

MID had *Deemed* status and did not provide a PIP for validation in 2004-2005. There were, therefore, no prior-year recommendations for follow-up.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

MID's 2004 CAHPS results showed performance in the NCQA national 50th to 75th percentiles for the How Well Doctors Communicate composite score. Results that fell below the 25th percentile included the Rating of Specialist and Rating of Health Plan, and the composite scores for Getting Needed Care, Getting Care Quickly, and Courteous and Helpful Office Staff. It was suggested that **MID** explore whether connections exist between the negative experiences reported by members and areas of concern highlighted by the HEDIS results and target interventions as appropriate. **MID**'s 2005 CAHPS results showed significant improvement in the Rating of Health Plan. **MID**'s 2005 QI evaluation stated that the plan continued to promote appropriate communication with office staff, doctors, and members through a variety of methods.

Conclusions and Recommendations

The current review of **MID** showed both strengths and opportunities for improvement. The results from the annual compliance review, yearly improvement in more than 90 percent of the performance measures, and PIP represented definite areas of strength for **MID**, at or approaching best practices. MDCH might want to consider various methods to generalize the policies and practices at **MID** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **MID** should focus on the review elements not passed in Quality/Utilization (one element) and Fraud and Abuse (2 elements). These elements represented defined opportunities for improvement. Nonetheless, **MID** passed 28 of 31 assessed elements (90.3 percent), providing evidence that the annual compliance review was an area of strength overall, with specific opportunities for improvement.

From the assessment of the performance measures, five rates were above the national Medicaid HEDIS 2004 75th percentiles: Childhood and Adolescent Immunization Combo 2, Diabetes Care—LDL-C Level <130 and <100, and Adolescent Well-Care Visits. The rates for several of the measures substantively improved. These measures represented relative areas of strength for **MID**.

Nonetheless, **MID** should focus on eight measures as opportunities for improvement: Breast Cancer Screening; Chlamydia Screening, 16–20 Years and Combined; Asthma 5–9 Years and 10–17 Years; Well-Child 1st 15 Months, 0 Visits; Timeliness of Prenatal Care; and Postpartum Care. These measures all scored below the national Medicaid HEDIS 2004 25th percentiles. Furthermore, **MID** should focus improvement efforts on the three measures that declined between measurement years: Breast Cancer Screening (which also needs improvement due to its 2005 rate), Diabetes Care—LDL-C Level <100, and Adults' Access 20–44 Years.

PIPs were shown to be an area of strength. **MID** scored 100 percent on all elements, evidencing an area of strength and potential best practices.

The assessment of the CAHPS scores showed improving results in need of continued improvement. The below-average national comparison for Courteous and Helpful Office Staff suggested that this measure had the highest opportunity for improvement. Nonetheless, although all rates improved between 2004 and 2005, none of the rates was as high as the 75th national Medicaid percentile. This

finding suggests that an overarching approach to quality improvement should be considered for the types of characteristics assessed by the CAHPS measures.

For Quality, Timeliness, and Access, the averages for **MID** were similar to the statewide averages, indicating overall average performance. Although none of the differences between **MID**'s scores and the statewide averages was substantively large, the averages for the performance measures were below the statewide averages in all three domains. These findings indicated that **MID** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table I-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 5/5 represents five out of a total of five standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table I-1—MOL Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for MOL		State Average
	Number	Percent	
Administrative	5/5	100%	97.0%
Provider	3/6	50.0%	88.5%
Member	4/4	100%	93.9%
Quality/Utilization	7/8	87.5%	82.8%
MIS/Data Reporting/Claims Processing	1/2	50.0%	85.5%
Fraud and Abuse	10/11	90.9%	86.1%

The table shows that **MOL**'s rates exceed the statewide average for four of the six categories of standards: Administrative, Member, Quality/Utilization, and Fraud and Abuse. These categories were apparent strengths for **MOL**.

The other two standards (i.e., Provider and MIS/Data Reporting/Claims Processing) appeared to show similar opportunities for improvement but actually did so to functionally different extents. For Provider, the **MOL** rate of 50.0 percent represented at least a few opportunities for improvement. **MOL** did not meet three of the six elements for the category and could have met two additional elements without exceeding the statewide average of 88.5 percent. For MIS/Data Reporting/Claims Processing, meeting a single additional element would have resulted in the rate moving from 50.0 percent to a perfect score for the category, exceeding the statewide average of 85.5 percent. Given this information, it would seem that the three missed elements in the Provider category would be the highest-priority opportunity for improvement for **MOL** within the annual compliance review.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table I-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table I-2—MOL Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	65.7%	69.9%	★★★
Adolescent Immunization Combo 2	27.1%	46.6%	★★★
Appropriate Treatment for Children With URI	71.4%	76.5%	★★
Breast Cancer Screening	53.4%	57.0%	★★
Cervical Cancer Screening	59.0%	59.0%	★★
Controlling High Blood Pressure	55.0%	62.1%	★★
Chlamydia Screening, 16–20 Years	44.6%	44.1%	★★
Chlamydia Screening, 21–26 Years	47.7%	51.1%	★★
Chlamydia Screening (Combined)	46.1%	47.5%	★★
Diabetes Care—HbA1c Testing	75.4%	88.8%	★★★
Diabetes Care—Poor HbA1c Control*	55.1%	43.0%	★★
Diabetes Care—Eye Exam	44.4%	52.3%	★★
Diabetes Care—LDL-C Screen	65.8%	84.5%	★★★
Diabetes Care—LDL-C Level <130	45.3%	53.0%	★★
Diabetes Care—LDL-C Level <100	24.8%	33.9%	★★★
Diabetes Care—Nephropathy	37.5%	49.6%	★★
Asthma 5–9 Years	68.5%	65.3%	★★
Asthma 10–17 Years	62.7%	63.5%	★★
Asthma 18–56 Years	69.7%	70.9%	★★
Asthma Combined Rate	67.9%	67.9%	★★
Medical Assistance With Smoking Cessation	68.8%	67.9%	★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table I-2—MOL Scores for Performance Measures			
Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Well-Child 1st 15 Months, 0 Visits*	4.5%	5.4%	★
Well-Child 1st 15 Months, 6+ Visits	38.1%	35.2%	★
Well-Child 3rd–6th Years of Life	54.2%	55.3%	★★
Adolescent Well-Care Visits	34.6%	33.6%	★★
Timeliness of Prenatal Care	70.2%	82.0%	★★
Postpartum Care	45.7%	58.8%	★★
Children's Access 12–24 Months	90.6%	91.4%	★★
Children's Access 25 Months–6 Years	78.5%	77.1%	★
Children's Access 7–11 Years	77.6%	72.9%	★
Adolescents' Access 12–19 Years	78.4%	73.4%	★
Adults' Access 20–44 Years	74.4%	78.8%	★★
Adults' Access 45–64 Years	81.8%	84.6%	★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table I-2 shows that **MOL**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for five performance measures (Childhood and Adolescent Immunization Combo 2, Diabetes Care—HbA1c Testing, Diabetes Care—LDL-C Screen, and Diabetes Care—LDL-C Level <100). These five measures represented relative areas of strength for **MOL**, assessed through national comparisons.

The table also shows that rates for 23 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Five rates were below national Medicaid HEDIS 2004 25th percentiles. These rates were: Well-Child 1st 15 Months, 0 Visits; Well-Child 1st 15 Months, 6+ Visits; Children's Access 25 Months–6 Years; Children's Access 7–11 Years; and Adolescents' Access 12–19 Years. These measures represented relative opportunities for improvement for **MOL** compared with national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. The rates improved for 24 of the 33 (72.7 percent) performance measures compared with rates reported in 2004. Notably, Adolescent Immunization Combo 2 increased from 27.1 percent to 46.6 percent and Diabetes Care—LDL-C Screen increased from 65.8 percent to 84.5 percent.

Rates decreased for nine (27.3 percent) of the performance measures compared with 2004. Of these nine measures, five measures were also below the 25th national Medicaid percentile. From a quality improvement perspective, these five measures (two well-child and three access measures) represent high-priority opportunities for improvement that should be addressed as expeditiously as possible by **MOL**.

Validation of Performance Improvement Projects (PIPs)

MOL's results for the Blood Lead Testing PIP are presented in Table I-3 and Table I-4. Table I-3 shows that all critical elements were determined to be *Met,* resulting in a critical score of 100 percent. Overall, **MOL** achieved a *Met* validation status with an overall score of 89 percent for its Blood Lead Testing PIP.

Table I-3—Overall PIP Scores *for* MOL	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**89%**
Validation Status	***Met***

Table I-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met*, *Partially Met*, *Not Met*, or scored as *NA*.

Table I-4—PIP Activity Scores *for* MOL						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	5	1	0	5
VII.	Appropriate Improvement Strategies	4	4	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	1	0
IX.	Real Improvement Achieved	4	2	1	1	0
X.	Sustained Improvement Achieved	1	0	1	0	0
Totals for all Activities		**53**	**42**	**3**	**2**	**6**

For all 53 PIP elements (including critical elements) evaluated, 42 were *Met*, 3 were *Partially Met*, 2 were *Not Met*, and 6 were *NA*. The findings indicated that **MOL** had difficulty with data collection, analysis and interpretation, real improvement, and sustained improvement. These findings suggest that **MOL** needs to focus on providing the required information at the needed level of detail when documenting its PIPs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **MOL**'s composite CAHPS scores are shown in Table I-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table I-5—MOL Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	62.3%	73.0%	2.44	2.62	★★
Getting Care Quickly	45.9%	47.7%	2.18	2.25	★★★
How Well Doctors Communicate	56.3%	62.7%	2.38	2.50	★★
Courteous and Helpful Office Staff	66.4%	68.3%	2.51	2.58	★★
Customer Service	NA	69.3%	NA	2.64	★★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all four of the top box percentages and three-point means reported in 2004 showed improvement in 2005 (Customer Service did not have a sufficient number of respondents for 2004). For 2005, the performance level was above average for two measures (i.e., Getting Care Quickly and Customer Service) from a national perspective. This finding indicated a strength for **MOL**.

MOL scored about average for the other three measures (i.e., Getting Needed Care, How Well Doctors Communicate, and Courteous and Helpful Office Staff) compared with the national Medicaid percentiles. **MOL** should consider the three measures potential opportunities for improvement but not necessarily a high priority.

MOL's detailed scores for global ratings are presented in Table I-6 on page I-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table I-6—MOL Detailed Scores for the CAHPS 3.0H Global Ratings					
CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	50.6%	58.6%	2.30	2.45	★★
Rating of Specialist	54.3%	55.8%	2.38	2.39	★★
Rating of All Health Care	45.6%	52.4%	2.21	2.33	★★
Rating of Health Plan	35.2%	44.6%	2.00	2.22	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all four measures improved from 2004 to 2005, a recognized strength for **MOL**. Yet, the 2005 scores for all four measures were about average from a national perspective. This finding suggested that these measures were continuing opportunities for improvement for all four of the global ratings. Importantly, some of the gains made on these measures would be building on substantively large prior gains, such as Rating of Health Plan, which increased from 35.2 percent in 2004 to 44.6 percent in 2005.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

MOL's 2004 on-site review results showed some performance strengths, specifically in the core areas of Administrative, Member, and Quality Assurance/Utilization Review. The results indicated that **MOL** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; and programs for individuals with special health care needs. However, a number of opportunities for improvement existed for **MOL** to achieve full compliance with the requirements of the Medicaid managed care contract. **MOL** received the highest number of nonpassing scores among all the MHPs and was one of only three MHPs to receive a *Fail* score for one of the standards. **MOL** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider, MIS/Data Reporting/Claims Processing, and Fraud and Abuse.

MOL's action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that **MOL**:

- Develop, follow, and maintain a policy to ensure that subcontracts and/or delegation agreements are submitted to the DMB 21 days before the effective date of the subcontract and/or delegation agreement. The November 2004 on-site review found that **MOL** had addressed this issue and that the **MOL** policy, Subcontract/Delegated Agreement Compliance, effective January 2, 2004, and revised November 8, 2004, was developed to help maintain compliance with this criterion.
- Amend the Oakland County Community Mental Health Services Program (CMHSP) agreement to address data and reporting requirements and quality assurance coordination. **MOL** must have CMHSP agreements that are executed, dated, and in effect for the counties of Arenac, Bay, Genesee, Tuscola, and Wayne. The October 2005 on-site review included detailed information about the current status of CMHSP agreements.
- Add hospital affiliation to the specialist information in the provider directory. The October 2005 on-site review found that the November 2004 provider directory contained all the required elements for each county in the approved service areas.
- Continue efforts to obtain hospital contracts in the **MOL** service areas where the plan has no contracted hospitals. At the 2003 on-site visit, **MOL** received an *Incomplete* on this criterion because no hospitals were contracted in Allegan, Bay, Huron, Manistee, Mason, and Saginaw counties. The November 2004 on-site review found that there were still counties in which **MOL** did not have hospital contracts: Allegan, Bay, Huron, Manistee, Mason, and Saginaw. Efforts were still under way to contract with several of the hospitals. **MOL** demonstrated that covered services were available and accessible. **MOL** has 39 counties in its Medicaid service area.
- Submit all required reports by the due date—specifically, the audited financial statement. The November 2004 on-site review found that **MOL** had submitted all reports by the required due date.

- Revise its fraud and abuse policies to address methods of detecting fraud and abuse by employees and members. The October 2005 on-site review included details on the processes used by the Anti-Fraud and Abuse Workgroup to detect fraud and abuse by providers, members, and employees.
- Begin using or adapt the current processes/reports specified in the plan's process to detect and eliminate fraud and abuse by members. If fraud or abuse is noted, the plan's committee meeting minutes should reflect discussion of the member's issue(s) and any corrective plan instituted. **MOL** should notify MDCH/PIS of any instance of member fraud or abuse. The November 2005 on-site review stated that **MOL** provided the Anti-Fraud and Abuse Workgroup minutes for four meetings describing the internal processes, including the outcomes, that are used to determine areas at risk for potential fraud and abuse by members.
- Revise its credentialing/recredentialing policies to address reviewing the Excluded Parties List System (EPLS) when verifying provider credentials during the credentialing/recredentialing process. The October 2005 on-site review did not address this issue.

MOL's Quality Improvement Program 2003 Annual Evaluation noted that many hospitals and practitioners in rural areas were averse to managed care, and that this was a barrier to access and availability. One of the interventions mentioned was promoting the financial strength of the plan to physicians, providers, and hospitals. It was recommended that efforts should continue to be focused on targeted communications to hospitals and providers to improve their perceptions of **MOL**. No mention of this issue was included in **MOL**'s 2005 QI evaluation.

Performance Measures

Performance was average in FY 2005 for women's health-related measures and it was recommended that these measures remain a focus of future improvement activities. Continued evaluation and implementation of these interventions was recommended. **MOL**'s 2005 QI program evaluation stated that significant attention was placed on women's health, which brought about an improvement in screening scores for breast cancer, cervical cancer, and chlamydia. The evaluation noted that women's health still continues to be an area that requires great attention.

It was recommended in FY 2005 that **MOL** reevaluate the diabetes and asthma disease management programs to ensure their effectiveness. No mention of these issues was included in **MOL**'s 2005 QI evaluation.

Performance Improvement Projects (PIPs)

MOL showed opportunities for improvement in its 2004–2005 Childhood Immunization PIP in Activity 6, Element 1, "Define data elements to be collected;" Activity 6, Element 11, Data Completeness;" Activity 8, Element 4, "Interpretation of Findings;" and Activity 8, Element 7, "Identify statistical difference between measurement periods." Although the topics differed, **MOL** showed improvement in clearly defining all data elements in its 2005–2006 Blood Lead Testing PIP, and showed partial improvement in data completeness. In 2004–2005, **MOL** did not provide the percentage of data completeness. For the 2005–2006 PIP, MDCH provided the data but **MOL** was responsible for rectifying its own data; consequently, this element received a *Partially Met*

score. **MOL** demonstrated improvement in interpreting the data findings in 2005–2006, but showed no improvement in statistical difference testing. No testing was performed in either PIP.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

MOL's CAHPS results reported in 2005 were not strong, with all the global ratings falling below the NCQA national 25th percentile. The composite scores for Getting Care Quickly and Courteous and Helpful Office Staff were between the 25th and 50th percentiles, while Getting Needed Care and How Well Doctors Communicate fell below the 25th percentile. These results contrasted with the stronger HEDIS results in Pediatric Care and some of the Women's Care dimensions. It was recommended that **MOL** explore whether there was a connection between members' negative experiences in accessing and receiving care and lower performance on the HEDIS Prenatal and Postpartum Care and Comprehensive Diabetes Care measures, as well as within the Access to Care dimension. No mention of these issues was included in **MOL**'s 2005 QI evaluation.

Conclusions and Recommendations

The results for **MOL** suggested more plausible opportunities for improvement than they did strengths that might be generalized for others to share. For example, from the annual compliance review, two-thirds of the categories showed room for improvement through elements that were not passed. The six-element category, Provider, showed only half of the elements passed. Assessed numerically and proportionately, Provider should be a high-priority opportunity for improvement within the policies and procedures covered by the annual compliance review.

Within the performance measures, the rates for the Immunization Combo 2 measures (Childhood and Adolescent) and some of the diabetes measures were at or above the 75th national Medicaid percentiles. These rates suggested areas of strength within **MOL**. Alternatively, measures with rates that fell or were below the 25th national Medicaid percentiles presented opportunities for improvement. These measures were: Well-Child 1st 15 Months, 0 Visits; Well-Child 1st 15 Months, 6+ Visits; Children's Access 25 Months–6 Years; Children's Access 7–11 Years; and Adolescents' Access 12–19 Years.

Although the PIP scored an overall *Met*, the evaluation showed that 5 of 47 scored activities (11 percent) had opportunities for improvement by not having individually achieved a *Met* status. The five elements were fairly evenly distributed throughout the later half of the PIP documentation. Element-specific recommendations for improvement were contained in the PIP report.

A comparative assessment of the CAHPS composite scores showed that the lowest score was for Getting Care Quickly. The rate for Getting Care Quickly was between 15.0 and 25.3 percentage points lower than the other composite scores. Yet, this measure was one of only two measures with top box percentages and three-point means above the 75th national Medicaid percentile levels.

For the global measures, Rating of Health Plan was the most-likely priority for improvement. Its rate ranged from 7.8 to 14.0 percentage points lower than the other global measure rates, although all of the 2005 rates were about average from a national perspective.

In terms of Quality, Timeliness, and Access, the results for **MOL** were mixed, with five scores above the statewide averages, and six below. The results showed relative average performance. These findings indicated that **MOL** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table J-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 7/7 represents seven out of a total of seven standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table J-1—OCH Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for OCH		State Average
	Number	Percent	
Administrative	7/7	100%	97.0%
Provider	11/11	100%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	11/12	91.7%	82.8%
MIS/Data Reporting/Claims Processing	4/4	100%	85.5%
Fraud and Abuse	11/11	100%	86.1%

The table shows that **OCH** achieved perfect scores for five of the six categories of measures. Only Quality/Utilization failed to pass every element in its category. Overall, **OCH** passed 47 of 48 elements in the annual compliance review (i.e., 97.9 percent). Although the nonpassed element still represented an opportunity for improvement, the annual compliance review was viewed as an area of exemplary strength for **OCH** and represented best practices that should be shared with other MHPs.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table J-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table J-2—OCH Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	65.0%	65.0%**	★★
Adolescent Immunization Combo 2	9.8%	35.7%	★★
Appropriate Treatment for Children With URI	56.9%	74.7%	★★
Breast Cancer Screening	49.6%	47.4%	★
Cervical Cancer Screening	59.6%	58.4%	★★
Controlling High Blood Pressure	39.7%	39.2%	★
Chlamydia Screening, 16–20 Years	50.7%	56.7%	★★★
Chlamydia Screening, 21–26 Years	57.7%	63.9%	★★★
Chlamydia Screening (Combined)	54.0%	60.0%	★★★
Diabetes Care—HbA1c Testing	63.3%	69.1%	★
Diabetes Care—Poor HbA1c Control*	59.4%	62.9%	★
Diabetes Care—Eye Exam	32.6%	27.9%	★
Diabetes Care—LDL-C Screen	74.2%	72.1%	★★
Diabetes Care—LDL-C Level <130	52.6%	46.7%	★★
Diabetes Care—LDL-C Level <100	31.1%	31.1%	★★
Diabetes Care—Nephropathy	37.5%	37.1%	★★
Asthma 5–9 Years	49.3%	55.1%	★
Asthma 10–17 Years	52.5%	61.0%	★★
Asthma 18–56 Years	64.6%	70.9%	★★
Asthma Combined Rate	56.8%	64.3%	★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table J-2—OCH Scores for Performance Measures			
Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Medical Assistance With Smoking Cessation	70.3%	67.0%	★★
Well-Child 1st 15 Months, 0 Visits*	9.1%	1.6%	★★
Well-Child 1st 15 Months, 6+ Visits	19.9%	48.5%	★★
Well-Child 3rd–6th Years of Life	57.4%	59.3%	★★
Adolescent Well-Care Visits	29.6%	30.1%	★★
Timeliness of Prenatal Care	71.8%	64.7%	★
Postpartum Care	31.4%	40.5%	★
Children's Access 12–24 Months	86.3%	89.0%	★
Children's Access 25 Months–6 Years	74.5%	68.1%	★
Children's Access 7–11 Years	69.7%	70.2%	★
Adolescents' Access 12–19 Years	68.2%	70.8%	★
Adults' Access 20–44 Years	72.3%	70.3%	★
Adults' Access 45–64 Years	80.7%	78.2%	★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table J-2 shows **OCH**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for the three chlamydia measures. These measures represented an area of strength for **OCH**, assessed through national comparisons.

The table also shows that the rates for 16 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Fourteen rates were below national Medicaid HEDIS 2004 25th percentiles. These rates were: Breast Cancer Screening; Controlling High Blood Pressure; Diabetes Care for HbA1c Testing, Poor HbA1c Control, and Eye Exams; Asthma 5–9 Years; Prenatal and Postpartum Care; and all six measures of Children's, Adolescents', and Adults' Access. These measures represented relative opportunities for improvement for **OCH** compared with national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, one measure was rotated from 2004 and, therefore, was not included in this evaluation. Rates improved or stayed the same for 19 of the 32 (59.4 percent) nonrotated performance measures compared with rates reported in 2004. Notably, Adolescent Immunization Combo 2 increased from 9.8 percent to 35.7 percent; Well-Child 1st 15 Months, 0 Visits, improved from 9.1 percent to 1.6 percent (it is a reverse measure for which lower scores indicate better performance); and Well-Child 1st 15 Months, 6+ Visits, increased from 19.9 percent to 48.5 percent.

The rates decreased for 13 (40.6 percent) of the nonrotated performance measures compared with 2004. Of these 13 measures, 7 measures were also below the 25th national Medicaid percentiles (i.e., Breast Cancer Screening, Diabetes Care for Poor HbA1c Control and Eye Exams, Timeliness of Prenatal Care, Children's Access 25 Months–6 Years, and both measures of Adult Access.) These seven measures presented an especially important opportunity for improvement from the results of the performance measures.

Validation of Performance Improvement Projects (PIPs)

OCH's results for the Blood Lead Testing PIP are presented in Table J-3 and Table J-4. Table J-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. **OCH** achieved a *Met* validation status with an overall score of 97 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table J-3—Overall PIP Scores *for* OCH	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**97%**
Validation Status	***Met***

Table J-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table J-4—PIP Activity Scores *for* OCH						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	5	1	0	5
VII.	Appropriate Improvement Strategies	4	0	0	0	4
VIII.	Sufficient Data Analysis and Interpretation	9	0	0	0	9
IX.	Real Improvement Achieved	4	0	0	0	4
X.	Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities		**53**	**28**	**1**	**0**	**24**

For all 53 PIP elements evaluated, 28 were *Met*, 1 was *Partially Met*, zero were *Not Met*, and 24 were *NA*. The findings indicated that **OCH** understood the PIP process and was able to conduct and produce valid PIPs to the extent that the PIP had progressed when evaluated. An opportunity for improvement existed, however, for the element *Partially Met* in data collection.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **OCH**'s composite CAHPS scores are shown in Table J-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table J-5—OCH Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	66.3%	66.7%	2.51	2.52	★★
Getting Care Quickly	40.3%	43.1%	2.01	2.08	★
How Well Doctors Communicate	64.1%	64.3%	2.47	2.47	★★
Courteous and Helpful Office Staff	64.8%	64.7%	2.47	2.49	★
Customer Service	NA	75.5%	NA	2.65	★★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that three of the four top box percentages reported in 2004 showed improvement for 2005 (Customer Service did not have a sufficient number of respondents for 2004). In 2005, Customer Service showed the highest results using three frames of reference. Both its top box percentage and its three-point mean were the highest of the four composite scores. Plus, Customer Service was the only composite measure to score above the national Medicaid 75th percentile in 2005.

The How Well Doctors Communicate measure had about average performance for 2005 from a national perspective. Yet, Getting Care Quickly and Courteous and Helpful Office staff both scored below the Medicaid 25th percentile in 2005. For Getting Care Quickly, **OCH's** score only modestly increased, while the score for Courteous and Helpful Office Staff slightly decreased. Together, these findings strongly suggest that **OCH** should give priority to these measures as opportunities for improvement.

OCH's detailed scores for global ratings are presented in Table J-6 on page J-7. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table J-6—OCH Detailed Scores for the CAHPS 3.0H Global Ratings					
CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	63.7%	62.3%	2.51	2.46	★★
Rating of Specialist	63.7%	62.3%	2.47	2.48	★★
Rating of All Health Care	50.9%	53.9%	2.30	2.33	★★
Rating of Health Plan	48.6%	52.7%	2.24	2.27	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that two of the four measures improved from 2004 to 2005 and two declined, although none of the changes was substantively large. Furthermore, all of the 2005 results were about average from a national perspective. These findings suggested that the four global ratings could be opportunities for improvement but were probably not as high a priority as other measures highlighted in this report.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

OCH's 2004 on-site review results showed considerable performance strengths, particularly in the areas of Administrative, Member, Quality Assurance/Utilization Review and MIS/Data Reporting/Claims Processing. The results indicated that **OCH** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; information system requirements; financial and administrative reporting to MDCH; timeliness of payments; and management of enrollment data. Two opportunities for improvement were noted in order to achieve full compliance with the requirements of the Medicaid managed care contract. **OCH** submitted the required corrective action plan to MDCH to address an opportunity for improvement in the core areas of Provider and Fraud and Abuse. **OCH**'s action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that **OCH**:

- Continue to work with the Detroit-Wayne County Community Mental Health Agency to reach an agreement that contains all of the required provisions for behavioral health and developmental disability services. **OCH** must continue to give MDCH monthly updates on the progress and actions taken to obtain this agreement. This issue was not mentioned in the June 2005 on-site review report.
- Begin using a process to detect and eliminate fraud and abuse by providers using provider profiling, PA logs, and medical record reviews. If fraud or abuse is noted, the plan's committee meeting minutes should reflect discussion of the provider's issue(s) and any corrective action instituted. **OCH** should notify MDCH/PIS of any instance of provider fraud or abuse. At the June 2005 on-site review, **OCH** submitted evidence that these issues had been addressed.

Performance Measures

In 2004–2005, it was noted that the QI program indicated a need for increased provider participation in the diabetes disease management program. It was also noted that a proactive approach, including sending providers lists of their diabetic patients and provider-specific results for the diabetes HEDIS measure, has helped other health plans improve these rates. It was also recommended that **OCH** consider the use of reminder cards for members identified as noncompliant with screening recommendations (access to care for children, adolescents, and adults). **OCH**'s 2005 QI evaluation described efforts to improve access to services; however, these specific recommendations were not addressed.

Performance Improvement Projects (PIPs)

OCH had *Deemed* status and did not provide a PIP for validation in 2004–2005. There were, therefore, no prior-year recommendations for follow-up.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

OCH's 2004 CAHPS performance on the Rating of Personal Doctor measure fell between the NCQA national 75th and 90th percentiles. Two measures, Rating of Specialist and How Well Doctors Communicate, fell between the 50th to 75th percentiles. The Rating of All Health Care and Rating of Health Plan fell between the 25th and 50th percentiles, while Getting Needed Care, Getting Care Quickly, and Courteous and Helpful Office Staff scores fell below the 25th percentile. It was recommended that these findings be carefully reviewed in conjunction with the plan's low HEDIS scores. It was also recommended that interventions be considered to address members' access and care experiences while at the same time implementing QI activities to improve HEDIS rates. **OCH**'s 2005 QI evaluation did not describe specific interventions, but noted improvements in the 2005 CAHPS scores for Rating of All Health Care and Rating of Health Plan.

Conclusions and Recommendations

The current review of **OCH** showed both strengths and opportunities for improvement. The results from the annual compliance review and from the PIP represented definite areas of strength for **OCH**, at or approaching best practices. MDCH might want to consider various methods to generalize the policies and practices at **OCH** that seemed responsible for the exemplary performance in these areas. Nonetheless, equally important opportunities for improvement existed for the performance measures and CAHPS composite scores.

From the annual compliance review, the only element not passed was within Quality/Utilization. Although the element was an apparent opportunity for improvement, the annual compliance review, with 97.9 percent of all elements passed, was a recognized strength to **OCH**'s program.

The results from the performance measures review suggested that **OCH** had outstanding results for its policies and procedures as documented and assessed for the annual compliance review. But **OCH** was not seeing that outstanding performance translate into even average outcomes on its HEDIS measures. Only three of the measures had 2005 performance above the national 75th percentile, and these measures were all for chlamydia screening. Yet, a total of 19 measures (59.4 percent) were either below the national 25th percentile or had a decline in performance between 2004 and 2005, or both. This low performance might be partially due to data or documentation issues, but the results from the annual compliance review argued against data issues being a large part of the performance gap. In short, important and pervasive opportunities for improvement existed for **OCH's** performance measures.

PIPs were shown to be an area of strength. The only opportunity for improvement was in the data collection activity, where **OCH** did not meet the requirements of one of the six applicable elements within the activity.

The assessment of the CAHPS scores pointed to relatively flat results for **OCH,** with relatively high-priority opportunities for improvement for Getting Care Quickly and for Courteous and Helpful Office Staff. The only measure to score above the national 75th percentile in 2005 was Customer Service.

For the domains of Quality, Timeliness, and Access, **OCH**'s scores showed mixed results with six categories above the statewide averages and five below. The mixed results were consistent with overall average performance seen in the other areas of this report. The greatest opportunity for improvement was found in the performance measures, which were consistently below the statewide averages in all three domains. These findings indicated that **OCH** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table K-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 4/4 represents four out of a total of four standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table K-1—PMD Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for PMD		State Average
	Number	Percent	
Administrative	4/4	100%	97.0%
Provider	8/8	100%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	5/7	71.4%	82.8%
MIS/Data Reporting/Claims Processing	4/4	100%	85.5%
Fraud and Abuse	10/11	90.9%	86.1%

The table shows that **PMD** achieved perfect scores on four of the six categories of measures: Administrative, Provider, Member, and MIS/Data Reporting/Claims Processing. These areas were recognized strengths for **PMD** and may represent best practices by **PMD**.

The two scores below 100 percent were Quality/Utilization at 71.4 percent and Fraud and Abuse at 90.9 percent. The Quality/Utilization category failed to achieve a perfect score by two elements, and one element was not passed in the Fraud and Abuse category. These findings suggest prioritizing opportunities for improvement by correcting the issues with Quality/Utilization prior to Fraud and Abuse.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table K-2. The table shows each of the performance measures, the rates for each measure for 2004 and for 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table K-2—PMD Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	68.0%	73.0%	★★★
Adolescent Immunization Combo 2	48.2%	64.7%	★★★
Appropriate Treatment for Children With URI	73.7%	78.5%	★★
Breast Cancer Screening	59.5%	57.5%	★★
Cervical Cancer Screening	69.3%	66.2%	★★
Controlling High Blood Pressure	55.3%	64.2%	★★
Chlamydia Screening, 16–20 Years	64.5%	66.6%	★★★
Chlamydia Screening, 21–26 Years	65.1%	64.5%	★★★
Chlamydia Screening (Combined)	64.8%	65.5%	★★★
Diabetes Care—HbA1c Testing	84.5%	84.8%	★★★
Diabetes Care—Poor HbA1c Control*	35.8%	36.1%	★★★
Diabetes Care—Eye Exam	63.3%	63.3%	★★★
Diabetes Care—LDL-C Screen	88.7%	91.6%	★★★
Diabetes Care—LDL-C Level <130	60.6%	70.4%	★★★
Diabetes Care—LDL-C Level <100	32.5%	42.4%	★★★
Diabetes Care—Nephropathy	56.1%	64.8%	★★★
Asthma 5–9 Years	72.6%	76.5%	★★★
Asthma 10–17 Years	75.2%	70.1%	★★★
Asthma 18–56 Years	71.4%	74.4%	★★★
Asthma Combined Rate	73.0%	73.4%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table K-2—PMD Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Medical Assistance With Smoking Cessation	68.9%	69.0%	★★★
Well-Child 1st 15 Months, 0 Visits*	2.8%	2.8%**	★★
Well-Child 1st 15 Months, 6+ Visits	38.1%	38.1%**	★★
Well-Child 3rd–6th Years of Life	55.7%	57.4%	★★
Adolescent Well-Care Visits	33.8%	37.7%	★★
Timeliness of Prenatal Care	65.1%	79.6%	★★
Postpartum Care	53.0%	63.3%	★★
Children's Access 12–24 Months	90.9%	91.7%	★★
Children's Access 25 Months–6 Years	77.4%	78.8%	★★
Children's Access 7–11 Years	77.1%	77.4%	★
Adolescents' Access 12–19 Years	79.1%	79.1%	★★
Adults' Access 20–44 Years	74.7%	76.3%	★★
Adults' Access 45–64 Years	85.2%	84.3%	★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table K-2 shows that **PMD**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for 17 performance measures. These measures represented individual areas of strength for **PMD** and collectively suggested overall strong performance.

The table also shows that rates for 15 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Only one rate was below the national Medicaid HEDIS 2004 25th percentile, Children's Access 7–11 Years. This measure represented a higher-priority opportunity for improvement for **PMD** versus any of the other measures compared with the national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, two measures were rotated from 2004 and, therefore, were not included in this evaluation. The rates improved or remained the same for 25 of the 31 (80.6 percent) nonrotated performance measures compared with rates reported in 2004. The rates decreased for six (19.4 percent) of the performance measures compared with 2004. Notably, the rate for Adolescent Immunization Combo 2 increased from 48.2 percent in 2004 to 64.7 percent in 2005. By assessed change, as well as final rates compared with national benchmarks, **PMD** has shown the performance measures to be an overall area of strength.

Validation of Performance Improvement Projects (PIPs)

PMD's results for the Blood Lead Testing PIP are presented in Table K-3 and Table K-4. Table K-3 shows that the score for critical elements *Met* was 92 percent. Overall, **PMD** achieved a *Partially Met* validation status with an overall score of 89 percent for its Blood Lead Testing PIP.

Table K-3—Overall PIP Scores *for* PMD	
Percentage Score of Critical Elements *Met*	**92%**
Percentage Score of Evaluation Elements *Met*	**89%**
Validation Status	***Partially Met***

Table K-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met*, *Partially Met*, *Not Met*, or scored as *NA*.

Table K-4—PIP Activity Scores *for* PMD					
Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I. Appropriate Study Topic	6	6	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	1	0	1
IV. Correctly Identified Study Population	3	3	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0
VI. Accurate/Complete Data Collection	11	5	1	0	5
VII. Appropriate Improvement Strategies	4	3	0	0	1
VIII. Sufficient Data Analysis and Interpretation	9	7	0	2	0
IX. Real Improvement Achieved	4	2	0	1	1
X. Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities	**53**	**39**	**2**	**3**	**9**

For all 53 PIP elements (including critical elements) evaluated, 39 were *Met*, 2 were *Partially Met*, 3 were *Not Met*, and 9 were *Not Applicable*. The findings indicated that **PMD** had difficulty with clearly defining the study indicators, the data collection activity, data analysis and interpretation, and showing that real improvement had been achieved. These findings did not indicate that **PMD** was unable to conduct valid PIPs, but, rather, that **PMD** should improve the documentation of the description for the study indicators in future PIPs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **PMD**'s composite CAHPS scores are shown in Table K-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table K-5—PMD Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	67.7%	69.1%	2.52	2.57	★★
Getting Care Quickly	42.9%	40.9%	2.15	2.15	★★
How Well Doctors Communicate	58.3%	54.2%	2.45	2.40	★
Courteous and Helpful Office Staff	63.6%	64.6%	2.52	2.53	★★
Customer Service	63.8%	NA	2.52	NA	NA

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that two of the four top box percentages reported in 2004 and 2005 improved and two declined. Customer Service did not have a sufficient number of respondents for 2005. For 2005, the performance level was average for three of the four measures compared with the national Medicaid percentiles. The How Well Doctors Communicate measure was below the 25th percentile of national Medicaid performance. These twin findings suggested that somewhat small improvements were made between 2004 and 2005, but an opportunity for improvement still existed in the four reporting measures, especially How Well Doctors Communicate.

PMD's detailed scores for global ratings are presented in Table K-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table K-6—PMD Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	56.0%	55.7%	2.39	2.40	★★
Rating of Specialist	62.5%	52.5%	2.50	2.36	★
Rating of All Health Care	49.3%	48.0%	2.29	2.27	★★
Rating of Health Plan	45.7%	45.9%	2.21	2.24	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows substantively flat or declining results for 2005 compared with 2004. Although the resulting scores were about average compared with the national Medicaid percentiles for three of the four global ratings, Rating of Specialist was below the national Medicaid 25th percentile and represented a higher-priority opportunity for improvement than the other measures.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

PMD's 2004 on-site review results showed some performance strengths, specifically in the core areas of Administrative and Member. The results indicated that **PMD** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; content and distribution of member materials; and processes for handling grievances, appeals, and State fair hearing requests. A number of opportunities for improvement existed for **PMD** to achieve full compliance with the requirements of the Medicaid managed care contract. **PMD** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider, Member, Quality Assurance/Utilization Review, MIS/Data Reporting/Claims Processing, and Fraud and Abuse. **PMD**'s action plan was deemed acceptable by MDCH in terms of scope, content, and established timeline, with one exception indicated below. The action plan submitted to MDCH required that the plan:

- Submit the most recent provider directory for review and approval by MDCH. The February 2005 on-site review stated that **PMD**'s provider network directory was approved by MDCH on November 9, 2004.
- Revise the Benefits Determination policy to comply with the standard authorization decision time frames set forth in the MDCH contract. This issue was not mentioned in the February 2005 on-site review report.
- Develop a plan for submitting all required reports by the due dates. The February 2005 on-site review found that **PMD** submitted all reports by the required due date.
- Revise its fraud and abuse policies to address methods of detecting fraud and abuse committed by employees, and to contain the definitions of fraud and abuse as stated in 42 CFR 455.2. The February 2005 on-site review indicated that **PMD** had addressed this area.
- Begin reviewing the grievance log with a focus on detecting fraud and abuse by providers. The February 2005 on-site review indicated that **PMD** had addressed this area.
- Begin reporting instances of fraud and abuse to MDCH/PIS. The February 2005 on-site review indicated that **PMD** had addressed this area.
- Provide to employees, at a minimum annually, the contact information necessary to report fraud and abuse to both the plan and MDCH/PIS. This action was originally deemed unacceptable by MDCH because **PMD** did not provide the method(s) that the plan would use to communicate this requirement to its employees. It was suggested that **PMD** place this information in employee newsletters, fliers, information on bulletin boards, etc. The February 2005 on-site review indicated that **PMD** had addressed this area.

Performance Measures

PMD's 2004 QI Program Evaluation indicated that a QI initiative focused on improving EPSDT services to children 3 to 6 years of age. In 2004–2005, it was noted that the initiative was relatively new and improvement in rates should be realized over time. If determined to be effective, it was recommended that **PMD** consider expanding the program to other age groups. **PMD**'s 2005 QI evaluation did not address EPSDT services.

It was noted in FY 2005 that the Healthy Mom, Healthy Baby program offered by **PMD** was an excellent program that included various interventions and a barrier analysis. Although participation in the program was high, only 46 percent of pregnancies were known to the health plan prior to delivery. It was recommended that **PMD** explore other methods to identify pregnant members as early as possible. **PMD**'s 2005 QI evaluation stated that the 2005 participation rate for the Healthy Mom, Healthy Baby program was 97 percent of known pregnancies.

Performance Improvement Projects (PIPs)

PMD had *Deemed* status and did not provide a PIP for validation in 2004–2005. There were, therefore, no prior-year recommendations for follow-up.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

PMD's CAHPS results reported in 2005 for the overall Rating of Specialist global measure fell between the 75th and 90th NCQA national percentiles. The composite score for Customer Service was in the 50th to 75th percentile. The other global ratings and composite scores fell between the 25th and 50th percentiles except for the overall Rating of Health Plan, which was below the 25th percentile. It was noted that targeted efforts to improve members' experiences accessing and receiving care could be implemented in conjunction with QI activities designed to improve HEDIS scores for well-child visits, prenatal care, and access to care. This recommendation was not directly addressed in **PMD**'s 2005 QI evaluation.

Conclusions and Recommendations

The current review of **PMD** showed both strengths and opportunities for improvement. The results from previously highlighted measures from the annual compliance review and performance measures supported the finding of relative strength for **PMD**, at or approaching best practices. MDCH might want to consider various methods to generalize the policies and practices at **PMD** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **PMD** should continue to improve performance on the element not passed in Quality/Utilization and Fraud and Abuse. Nonetheless, of the 37 elements reviewed, **PMD** passed 34 (91.9 percent).

From the assessment of the performance measures, 17 rates were above the national Medicaid HEDIS 2004 75th percentiles. These measures represented relative areas of strength for **PMD**. The one measure that was below the 25th national Medicaid percentile was Children's Access 7–11 Years. This measure represented the most apparent opportunity for improvement within the performance measures. Additionally, the six measures with rates that declined were also noted opportunities for improvement. Lastly, **PMD** might want to target the measures that scored at an average level from a national perspective.

The PIP scores indicated an additional opportunity for improvement. With an overall score of *Partially Met*, the PIP needed improvement within the following activities: clearly defining the study indicators, the data collection activity, data analysis and interpretation, and showing that real improvement had been achieved.

The assessment of the CAHPS scores suggested mixed and relatively flat performance overall. The two measures, How Well Doctors Communicate and Rating of Specialist, were the two areas showing the highest-priority opportunities for improvement from a national perspective.

For all three domains of Quality, Timeliness and Access, **PMD**'s averages for annual compliance reviews and performance measures were higher than the statewide averages, while the averages for PIPs and CAHPS were below the statewide averages. The averages for the annual compliance reviews were consistently the highest in all three areas. The averages for CAHPS were consistently the lowest scores. As seen in the CAHPS section, **PMD** should focus on provider communication and access to care to improve member satisfaction. These findings indicated that **PMD** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table L-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 7/7 represents seven out of a total of seven standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table L-1—PSW Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for PSW		State Average
	Number	Percent	
Administrative	7/7	100%	97.0%
Provider	8/8	100%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	4/5	80.0%	82.8%
MIS/Data Reporting/Claims Processing	4/4	100%	85.5%
Fraud and Abuse	10/11	90.9%	86.1%

The table shows that **PSW** achieved perfect scores for four of the six categories under compliance review measures: Administrative, Provider, Member, and MIS/Data Reporting/Claims Processing. These four categories were recognized strengths for **PSW**. For the two remaining categories, Quality/Utilization and Fraud and Abuse, only one element was not passed in each category. This finding of passing 36 of 38 total elements (i.e., 94.7 percent) suggested that a relatively modest effort by **PSW** could result in perfect scores in all six categories of the compliance review measures. Overall, **PSW**'s performance on the annual compliance review measures suggested some best practices that might be shared with other MHPs.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support systems to report accurate HEDIS measures. The results of this assessment are presented in Table L-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table L-2—PSW Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	77.6%	78.3%	★★★
Adolescent Immunization Combo 2	39.7%	58.6%	★★★
Appropriate Treatment for Children With URI	74.0%	76.7%	★★
Breast Cancer Screening	60.9%	56.5%	★★
Cervical Cancer Screening	65.7%	64.5%	★★
Controlling High Blood Pressure	48.2%	59.6%	★★
Chlamydia Screening, 16–20 Years	43.9%	46.1%	★★
Chlamydia Screening, 21–26 Years	47.1%	48.2%	★★
Chlamydia Screening (Combined)	45.6%	47.2%	★★
Diabetes Care—HbA1c Testing	83.7%	82.0%	★★
Diabetes Care—Poor HbA1c Control*	48.9%	36.5%	★★★
Diabetes Care—Eye Exam	34.5%	49.9%	★★
Diabetes Care—LDL-C Screen	78.8%	85.4%	★★★
Diabetes Care—LDL-C Level <130	41.6%	54.5%	★★
Diabetes Care—LDL-C Level <100	26.3%	35.0%	★★★
Diabetes Care—Nephropathy	45.0%	41.1%	★★
Asthma 5–9 Years	77.7%	76.4%	★★★
Asthma 10–17 Years	68.8%	69.2%	★★★
Asthma 18–56 Years	69.0%	73.0%	★★★
Asthma Combined Rate	70.5%	72.6%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table L-2—PSW Scores for Performance Measures			
Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Medical Assistance With Smoking Cessation	68.5%	67.0%	★★
Well-Child 1st 15 Months, 0 Visits*	1.5%	1.3%	★★
Well-Child 1st 15 Months, 6+ Visits	38.0%	44.3%	★★
Well-Child 3rd–6th Years of Life	56.7%	49.1%	★
Adolescent Well-Care Visits	33.3%	32.1%	★★
Timeliness of Prenatal Care	79.5%	81.0%	★★
Postpartum Care	47.7%	61.6%	★★
Children's Access 12–24 Months	96.6%	94.3%	★★
Children's Access 25 Months–6 Years	84.5%	77.8%	★★
Children's Access 7–11 Years	83.1%	81.3%	★★
Adolescents' Access 12–19 Years	82.4%	81.6%	★★
Adults' Access 20–44 Years	81.9%	81.2%	★★
Adults' Access 45–64 Years	91.1%	87.7%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table L-2 shows that **PSW**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for 10 performance measures. These measures represented individual areas of strength for **PSW** and collectively suggested strong performance overall.

The table also shows that rates for 22 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Only one rate was below the national Medicaid HEDIS 2004 25th percentile, Well-Child 3rd–6th Years of Life. This measure represented a higher-priority opportunity for improvement for **PSW** versus any of the other measures when compared with national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. Rates improved for 19 of the 33 (57.6 percent) performance measures compared with rates reported in 2004. Rates decreased for 14 (42.4 percent) of the performance measures compared with 2004. Notably, the rate for Adolescent Immunization Combo 2 increased from 39.7 percent in 2004 to 58.6 percent in 2005.

Validation of Performance Improvement Projects (PIPs)

PSW's results for the Blood Lead Testing PIP are presented in Table L-3 and Table L-4. Table L-3 shows that all critical elements were determined to be *Met*, resulting in a critical score of 100 percent. Overall, **PSW** achieved a *Met* validation status with an overall score of 91 percent for its Blood Lead Testing PIP.

Table L-3—Overall PIP Scores *for* PSW	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**91%**
Validation Status	***Met***

Table L-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table L-4—PIP Activity Scores *for* PSW						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	5	1	0	5
VII.	Appropriate Improvement Strategies	4	4	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	1	0
IX.	Real Improvement Achieved	4	3	0	1	0
X.	Sustained Improvement Achieved	1	0	1	0	0
Totals for all Activities		**53**	**43**	**2**	**2**	**6**

For all 53 PIP elements (including critical elements) evaluated, 43 were *Met*, 2 were *Partially Met*, 2 were *Not Met*, and six were *NA*. The findings indicated **PSW** had difficulty with data collection, analysis and interpretation, evidencing real improvement, and sustained improvement. These findings suggest that **PSW** needs to increase its focus on providing the required information at the needed level of detail when documenting its PIPs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **PSW**'s composite CAHPS scores are shown in Table L-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table L-5—PSW Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	69.0%	70.3%	2.57	2.57	★★
Getting Care Quickly	39.8%	40.9%	2.13	2.14	★★
How Well Doctors Communicate	54.8%	55.8%	2.40	2.42	★★
Courteous and Helpful Office Staff	62.1%	63.7%	2.50	2.52	★★
Customer Service	NA	NA	NA	NA	NA

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that the four top box percentages reported in 2004 all improved for 2005 (Customer Service did not have a sufficient number of respondents for 2004 or for 2005). For 2005, the performance level was average for all four displayed measures compared with the national Medicaid percentiles. These twin findings suggested that somewhat small improvements were made between 2004 and 2005, but an opportunity for improvement still existed in all four composite measures.

PSW's detailed scores for the global ratings are presented in Table L-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table L-6—PSW Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	57.3%	56.5%	2.43	2.39	★★
Rating of Specialist	55.8%	60.0%	2.41	2.48	★★
Rating of All Health Care	47.3%	49.3%	2.27	2.28	★★
Rating of Health Plan	43.9%	46.4%	2.21	2.24	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that three of the four measures improved from 2004 to 2005. Rating of Personal Doctor fell by just 0.8 percentage points. All four of the 2005 rates were about average from a national perspective. Comparatively, these average national ratings indicated continuing opportunities for improvement, especially for Rating of Personal Doctor, where the satisfaction rating declined a small amount.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

PSW's FY 2005 on-site review results showed performance strengths in the core areas of Administrative, Provider, Member, and MIS/Data Reporting/Claims Processing. The results indicated that **PSW** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; subcontracted and delegated functions; provisions for the scope of covered services; primary care providers; network adequacy; provider relations; content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; and information system requirements, financial and administrative reporting to MDCH, timeliness of payments, and management of enrollment data. A number of opportunities for improvement existed for **PSW** to achieve full compliance with the requirements of the Medicaid managed care contract, particularly in the area of Fraud and Abuse. **PSW** received five *Incomplete* scores in this core area, representing the highest number of standards receiving a nonpassing score in a single core area across all MHPs.

PSW submitted the required corrective action plan to MDCH to address an opportunity for improvement in the core areas of Quality Assurance/Utilization Review and Fraud and Abuse. **PSW**'s action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that **PSW**:

- Approve and implement the draft care management policy for compliance with the standard authorization time frame set forth in the MDCH contract. This issue was not addressed in the April 2005 site visit report.
- Update its policy to address a process to guard against fraud and abuse by members. The April 2005 site visit report indicated that this area had been addressed by **PSW**.
- Begin using or adapt the current processes/reports specified in the plan's process to detect fraud and abuse by providers. If fraud or abuse is noted, the plan's committee meeting minutes should reflect the discussion of the provider's issue(s) and any corrective action instituted. **PSW** should notify MDCH/PIS of any instance of provider fraud or abuse. The April 2005 site visit report indicated that this area had been addressed by **PSW**.
- Begin using member service inquiries/complaints to detect fraud and abuse by members. **PSW** should notify MDCH/PIS of any instance of member fraud or abuse. The April 2005 site visit report indicated that this area had been addressed by **PSW**.
- Provide to members the telephone number for MDCH/PIS to report fraud and abuse. The April 2005 site visit report cited a copy of an e-mail sent to employees on March 21, 2005, that included the definition of fraud and abuse, examples of provider and member fraud, the toll-free telephone number of the plan and MDCH/PIS, and how employees could report fraud and abuse to the plan and/or MDCH/PIS. However, no address for the plan or MDCH/PIS was given. Information was given that reporting of fraud and/or abuse could be done anonymously.

PSW's 2004 QI Work Plan called for quarterly monitoring and evaluation of care management activities, and quarterly reports of potential fraud and abuse activity. However, opportunities for

improvement continued to exist in these areas. The 2006 QI Work Plan included activities to monitor care management activities quarterly, but did not address fraud and abuse.

Performance Measures

In FY 2005, it was recommended that **PSW** continue to expand its efforts to improve well-child visit rates. **PSW**'s 2005 QI evaluation stated that well-child visits for children 3 to 6 years of age and adolescents continued to be a challenge for the plan. The evaluation described actions and interventions designed to improve these rates.

It was also recommended in FY 2005 that **PSW** continue its efforts to educate members regarding screening and early detection. The 2005 QI evaluation described actions and interventions designed to improve HEDIS rates in these areas.

Finally, it was recommended in FY 2005 that **PSW** reevaluate the diabetes disease management program, reviewing the process for participation to ensure that all eligible diabetics were informed of the program and were offered an opportunity to participate. It was noted that a proactive approach, including sending providers lists of their diabetic patients and provider-specific results for the diabetes HEDIS measure, had helped other health plans improve these rates. The 2005 QI evaluation noted only that **PSW** had continued with the diabetes disease management program.

Performance Improvement Projects (PIPs)

PSW showed opportunities for improvement in its 2004–2005 Diabetes Care PIP in Activity 5, Element 1, "True or estimated frequency of occurrence provided;" and Activity 6, Element 10, "Data collection process." Both areas showed improvement in the 2005–2006 Blood Lead Testing PIP. **PSW** included the estimated frequency of occurrence in the population and provided the data collection process.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

PSW's CAHPS results reported in 2005 for three global measures (Rating of Personal Doctor, Rating of Specialist, and Rating of All Health Care) and two composite scores (Getting Needed Care and Getting Care Quickly) fell between the NCQA national 25th and 50th percentiles. The overall Rating of Health Plan and composite scores for How Well Doctors Communicate and Courteous and Helpful Office Staff fell below the 25th percentile. It was suggested that **PSW** consider identifying the key drivers of the CAHPS measures and targeting interventions to improve members' experiences. The 2005 QI evaluation noted an intention to implement a CAHPS continuous quality improvement team in 2006.

Conclusions and Recommendations

The current review of **PSW** showed both strengths and opportunities for improvement. The results from the annual compliance review, the performance measures, and from the current PIP assessment represented definite areas of strength for **PSW**, some at or approaching best practices. MDCH might want to consider various methods to generalize the policies and practices at **PSW** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **PSW** should continue to work to improve Quality/Utilization processes, procedures, and documentation for the element that did not pass the review. Furthermore, **PSW** should rectify the Fraud and Abuse element that was not passed. The remaining elements within the annual compliance review were all passed.

From the assessment of the performance measures, 10 rates were above the national Medicaid HEDIS 2004 75th percentile. These measures represented relative areas of strength for **PSW**. Only one rate was below the 25th national Medicaid percentile, Well-Child 3rd–6th Years of Life. The rate for this measure declined from 2004 to 2005. These twin findings strongly indicated Well-Child 3rd–6th Years of Life as a high-priority opportunity for improvement. The rates for 11 other measures also declined, but not below the 25th national Medicaid percentile.

Although the PIP scored an overall *Met*, the evaluation showed that 4 of 47 scored activities (8.5 percent) had opportunities for improvement by not having individually achieved a *Met* status. The four elements were fairly evenly distributed throughout the later half of the PIP documentation. Element-specific recommendations for improvement are contained in the PIP report.

The assessment of the CAHPS scores suggested about average performance overall. Nonetheless, the Rating of Personal Doctor measure was seen as a higher-priority opportunity for improvement. This assessment was based on all current scores being about average from a national perspective and the measure being the only one that declined between 2004 and 2005.

In terms of Quality, Timeliness, and Access, the results for **PSW** were mixed, with five scores above the statewide averages and six below. The results showed relative average performance. These findings indicated that **PSW** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table M-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 4/4 represents four out of a total of four standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table M-1—PRI Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for PRI		State Average
	Number	Percent	
Administrative	4/4	100%	97.0%
Provider	9/10	90.0%	88.5%
Member	2/2	100%	93.9%
Quality/Utilization	5/5	100%	82.8%
MIS/Data Reporting/Claims Processing	1/2	50.0%	85.5%
Fraud and Abuse	10/11	90.9%	86.1%

The table shows that **PRI** achieved perfect scores for three of the six categories under compliance review measures: Administrative, Member, and Quality/Utilization. These three categories were recognized strengths for **PRI**. For the three remaining categories, Provider and Fraud and Abuse achieved somewhat higher scores than the statewide averages, while the score for MIS/Data Reporting/Claims Processing was lower. Nonetheless, one element was not passed in each of the three categories, suggesting that a relatively modest effort by **PRI** could result in perfect scores in all six categories of the compliance review measures.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table M-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table M-2—PRI Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	81.1%	88.8%	★★★
Adolescent Immunization Combo 2	48.2%	73.2%	★★★
Appropriate Treatment for Children With URI	87.5%	87.8%	★★★
Breast Cancer Screening	60.8%	57.4%	★★
Cervical Cancer Screening	79.9%	81.1%	★★★
Controlling High Blood Pressure	59.9%	63.8%	★★
Chlamydia Screening, 16–20 Years	49.9%	54.8%	★★★
Chlamydia Screening, 21–26 Years	52.4%	58.7%	★★★
Chlamydia Screening (Combined)	51.2%	56.9%	★★★
Diabetes Care—HbA1c Testing	84.2%	88.8%	★★★
Diabetes Care—Poor HbA1c Control*	38.4%	31.6%	★★★
Diabetes Care—Eye Exam	58.6%	58.4%	★★★
Diabetes Care—LDL-C Screen	85.6%	87.8%	★★★
Diabetes Care—LDL-C Level <130	60.6%	64.5%	★★★
Diabetes Care—LDL-C Level <100	35.5%	39.4%	★★★
Diabetes Care—Nephropathy	40.6%	47.0%	★★
Asthma 5–9 Years	79.4%	75.9%	★★★
Asthma 10–17 Years	84.0%	80.4%	★★★
Asthma 18–56 Years	73.1%	77.2%	★★★
Asthma Combined Rate	78.1%	78.1%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table M-2—PRI Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Medical Assistance With Smoking Cessation	71.3%	73.0%	★★★
Well-Child 1st 15 Months, 0 Visits*	0.3%	0.6%	★★★
Well-Child 1st 15 Months, 6+ Visits	51.7%	52.1%	★★
Well-Child 3rd–6th Years of Life	66.2%	64.2%	★★
Adolescent Well-Care Visits	39.7%	36.7%	★★
Timeliness of Prenatal Care	85.3%	86.9%	★★★
Postpartum Care	63.2%	58.4%	★★
Children's Access 12–24 Months	97.5%	97.2%	★★★
Children's Access 25 Months–6 Years	84.3%	83.4%	★★
Children's Access 7–11 Years	84.5%	83.5%	★★
Adolescents' Access 12–19 Years	80.5%	82.0%	★★
Adults' Access 20–44 Years	84.1%	84.3%	★★★
Adults' Access 45–64 Years	90.8%	91.7%	★★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table M-2 shows that **PRI**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for 23 of 33 performance measures overall (i.e., 69.7 percent). These measures represented individual areas of strength for **PRI** and collectively suggested overall strong performance.

The table also shows that rates for 10 of the 33 performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement. No measure presented a rate that was below national Medicaid HEDIS 2004 25th percentiles.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. The rates improved or remained the same for 22 of the 33 performance measures (66.7 percent) compared with rates reported in 2004. Notably, the rate for Adolescent Immunization Combo 2 substantively improved between 2004 and 2005 from 48.2 percent to 73.2 percent. The rates decreased for 11 (33.3 percent) of the performance measures compared with 2004.

Validation of Performance Improvement Projects (PIPs)

PRI's results for the Blood Lead Testing PIP are presented in Table M-3 and Table M-4. Table M-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. **PRI** achieved a *Met* validation status with an overall score of 98 percent for its Blood Lead Testing PIP. This score was indicative of exemplary conduct and documentation for a PIP.

Table M-3—Overall PIP Scores *for* PRI	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**98%**
Validation Status	***Met***

Table M-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table M-4—PIP Activity Scores *for* PRI						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	3	0	0	1
VIII.	Sufficient Data Analysis and Interpretation	9	9	0	0	0
IX.	Real Improvement Achieved	4	3	1	0	0
X.	Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities		**53**	**44**	**1**	**0**	**8**

For all 53 PIP elements evaluated, 44 were *Met*, 1 was *Partially Met*, zero were *Not Met*, and 8 were *NA*. The findings indicated that **PRI** understood the PIP process and was able to conduct and produce valid PIPs. Of the 45 scored elements (i.e., 53 total elements minus the 8 that were *NA*), **PRI** scored a *Met* on all but one.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **PRI**'s composite CAHPS scores are shown in Table M-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table M-5—PRI Detailed Results for CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	73.9%	77.9%	2.63	2.70	★★★
Getting Care Quickly	43.9%	46.2%	2.19	2.23	★★
How Well Doctors Communicate	56.7%	62.5%	2.42	2.52	★★★
Courteous and Helpful Office Staff	63.8%	65.6%	2.52	2.54	★★
Customer Service	66.8%	69.5%	2.57	2.61	★★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all five top box percentages and three-point means improved between 2004 and 2005. For 2005, the performance level was above average for three measures and about average for two measures compared compared with the national Medicaid percentiles. **PRI** should consider Getting Care Quickly and Courteous and Helpful Office Staff as potential opportunities for improvement, but should be commended both for the improvements made and for the composite scores that were above average from a national perspective.

PRI's detailed scores for the global ratings are presented in Table M-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table M-6—PRI Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	57.1%	59.9%	2.42	2.47	★★
Rating of Specialist	55.9%	60.3%	2.33	2.47	★★
Rating of All Health Care	50.0%	56.4%	2.27	2.42	★★
Rating of Health Plan	44.6%	54.0%	2.22	2.38	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all four measures improved from 2004 to 2005. Yet, the 2005 scores for all four measures were about average from a national perspective. This finding suggested opportunities for improvement for all four of the global ratings even though improvements would be building on prior gains.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

PRI's FY 2005 on-site review results showed performance strengths in all but one of the core areas. The results indicated that **PRI** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; subcontracted and delegated functions; provisions for the scope of covered services; primary care providers; network adequacy; provider relations; content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; and information system requirements, financial and administrative reporting to MDCH, timeliness of payments, and management of enrollment data. Two opportunities for improvement were noted, both in the area of Fraud and Abuse. This represented one of the best on-site review results across the MHPs. **PRI** submitted the required corrective action plan to MDCH to address its opportunities for improvement. **PRI**'s action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that the plan:

- Begin using definitions of fraud and abuse as stated in 42 CFR 455.2. The August 2005 on-site review indicated that this area had been addressed.
- Provide, at a minimum annually, to employers and providers the contact information necessary to report fraud and abuse to MDCH/PIS. The August 2005 on-site review indicated that this area had been addressed.

Performance Measures

PRI's QI Program Evaluation indicated a QI initiative focused on improving services to children 3 to 6 years of age. **PRI** was encouraged in FY 2005 to expand its efforts to improve well-child visit rates for all age groups. **PRI**'s 2005 QI evaluation stated that well-child visit rates in 2005 were flat or declined. Limited interventions were described.

It was recommended in FY 2005 that **PRI** continue its efforts to improve maternal care rates by exploring methods to identify pregnant members as early as possible. **PRI**'s 2005 QI evaluation stated that prenatal care in the first trimester increased slightly in 2005, and it described activities to improve this rate.

It was suggested in FY 2005 that a more comprehensive diabetes program be implemented to increase overall diabetes rates for **PRI**. The plan's 2005 QI evaluation stated that **PRI** continued to make improvements in quality of care and health outcomes for members with diabetes and that the program was effective in reducing preventable utilization and lowering health care costs.

Performance Improvement Projects (PIPs)

PRI had *Deemed* status and did not provide a PIP for validation in 2004–2005. There were, therefore, no prior-year recommendations for follow-up.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Three of **PRI**'s CAHPS composite scores reported in 2005 (Getting Needed Care, Getting Care Quickly, and Customer Service) fell between the NCQA national 50th to 75th percentiles. The other composite scores (How Well Doctors Communicate and Courteous and Helpful Office Staff) and three global ratings (Rating of Personal Doctor, Rating of All Health Care, and Rating of Health Plan) fell between the 25th to 50th percentiles. Rating of Specialist was below the 25th percentile. This solid performance in meeting members' needs when they access primary care services mirrored **PRI**'s strong HEDIS scores. It was recommended that **PRI** consider identifying the key drivers of the Rating of Specialist rating and designing and implementing appropriate interventions. This was not addressed in **PRI**'s 2005 QI evaluation.

Conclusions and Recommendations

The current review of **PRI** showed both strengths and opportunities for improvement. Selected results from all four areas (i.e., the annual compliance review measures, performance measures, PIP, and CAHPS) have been shown to be at or approaching best practices. MDCH might want to consider various methods to generalize the policies and practices at **PRI** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **PRI** should continue to improve performance on the element not passed in Provider, MIS/Data Reporting/Claims Processing, and Fraud and Abuse. Nonetheless, of the 34 elements reviewed, **PRI** passed 31 (91.2 percent). This overall performance showed a strength in **PRI**'s program.

From the assessment of the performance measures, 23 rates were above the national Medicaid HEDIS 2004 75th percentiles. These measures represented areas of strength for **PRI**. No measure was below the 25th national Medicaid percentile. Nonetheless, the 11 measures with rates that declined were noted opportunities for improvement. Notably, however, the rate for Adolescent Immunization Combo 2 increased from 48.2 percent in 2004 to 73.2 percent in 2005. Improvements of this magnitude can be considered best practices in quality improvement and should have their interventional strategies shared with other MHPs.

PIPs were shown to be an area of strength. The only opportunity for improvement was in area of evidencing real achievement, where **PRI** did not meet the requirements of one of the four applicable elements within the activity.

The assessment of the CAHPS scores suggested above-average performance for the composite scores and about average performance for the global scores compared with the national percentiles. Further, **PRI** should be commended for the improvements seen between 2004 and 2005 for all nine

CAHPS measures assessed. Nonetheless, **PRI** might consider the measures scoring about average from a national perspective to be opportunities for improvement.

For Quality, Timeliness, and Access, **PRI**'s main strengths were performance measures, PIPs and CAHPS. Except for the Access domain, **PRI**'s averages for the annual compliance reviews were lower than the statewide averages. **PRI** should focus on improving documentation of processes in terms of Quality and Timeliness. These findings indicated that **PRI** had a well-established QI program that met or exceeded the State's expectations for access to care, structure and operations, and quality measurement and improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table N-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 1/3 represents one out of a total of three standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table N-1—THC Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for THC		State Average
	Number	Percent	
Administrative	1/3	33.3%	97.0%
Provider	5/8	62.5%	88.5%
Member	1/4	25.0%	93.9%
Quality/Utilization	3/5	60.0%	82.8%
MIS/Data Reporting/Claims Processing	5/5	100%	85.5%
Fraud and Abuse	7/11	63.6%	86.1%

The table shows that **THC** achieved a perfect score for MIS/Data Reporting/Claims Processing. This category was recognized as a strength for **THC**. For the five remaining categories, **THC**'s scores showed substantively large opportunities for improvement from three different perspectives. First, not a single one of the five categories scored as high as 64.0 percent. Second, the scores in all five categories were substantively below their respective statewide averages. Third, if **THC** had passed an additional element in each one of the five categories, not a single score would yet reach the respective statewide average. Clearly, and with the noted exception of MIS/Data Reporting/Claims Processing, the annual compliance review measures, as a group, represented a high-priority opportunity for improvement that needed to be generalized across the assessed systems.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table N-2. The table separately shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table N-2—THC Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	66.7%	70.0%	★★★
Adolescent Immunization Combo 2	34.5%	57.9%	★★★
Appropriate Treatment for Children With URI	83.3%	73.3%	★
Breast Cancer Screening	41.1%	46.5%	★
Cervical Cancer Screening	56.6%	59.8%	★★
Controlling High Blood Pressure	52.8%	52.1%	★
Chlamydia Screening, 16–20 Years	47.5%	50.1%	★★
Chlamydia Screening, 21–26 Years	56.5%	63.5%	★★★
Chlamydia Screening (Combined)	51.8%	56.2%	★★★
Diabetes Care—HbA1c Testing	70.9%	76.4%	★★
Diabetes Care—Poor HbA1c Control*	55.9%	47.7%	★★
Diabetes Care—Eye Exam	38.5%	47.9%	★★
Diabetes Care—LDL-C Screen	71.2%	79.6%	★★
Diabetes Care—LDL-C Level <130	47.0%	56.0%	★★
Diabetes Care—LDL-C Level <100	26.4%	32.6%	★★
Diabetes Care—Nephropathy	39.0%	56.7%	★★★
Asthma 5–9 Years	52.9%	56.3%	★
Asthma 10–17 Years	58.1%	62.9%	★★
Asthma 18–56 Years	59.8%	72.7%	★★★
Asthma Combined Rate	57.5%	65.6%	★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table N-2—THC Scores for Performance Measures			
Performance Measures	**Rate for 2004**	**Rate for 2005**	**Performance Level for 2005**
Medical Assistance With Smoking Cessation	72.6%	71.7%	★★★
Well-Child 1st 15 Months, 0 Visits*	6.3%	6.7%	★
Well-Child 1st 15 Months, 6+ Visits	25.7%	24.0%	★
Well-Child 3rd–6th Years of Life	50.7%	55.6%	★★
Adolescent Well-Care Visits	34.7%	39.1%	★★
Timeliness of Prenatal Care	76.2%	86.3%	★★★
Postpartum Care	38.7%	46.9%	★
Children's Access 12–24 Months	87.5%	88.2%	★
Children's Access 25 Months–6 Years	71.5%	72.5%	★
Children's Access 7–11 Years	68.0%	71.5%	★
Adolescents' Access 12–19 Years	68.1%	72.5%	★
Adults' Access 20–44 Years	65.9%	70.6%	★★
Adults' Access 45–64 Years	74.1%	76.1%	★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table N-2 shows that **THC**'s rates were above the national Medicaid HEDIS 2004 75th percentiles for eight performance measures (i.e., Childhood and Adolescent Immunization Combo 2, Chlamydia Screening—21–26 Years and Combined, Diabetes Care—Nephropathy, Asthma 18–56 Years, Medical Assistance With Smoking Cessation, and Timeliness of Prenatal Care). These measures represented relative areas of strength for **THC**.

The table also shows that rates for 13 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. These measures represented neither relative areas of strength nor a necessarily high-priority opportunity for improvement.

Twelve rates were below the national Medicaid HEDIS 2004 25th percentile. These rates were: Appropriate Treatment for Children With URI; Breast Cancer Screening; Controlling High Blood Pressure; Asthma 5–9 Years; Well-Child 1st 15 Months, 0 Visits and 6+ Visits; Postpartum Care; and all measures of children's, adolescents', and adults' access to care except 20-44 years of age. These measures represented opportunities for improvement for **THC** compared with the national results.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. Rates improved for 28 of the 33 (84.8 percent) performance measures compared with rates reported in 2004. Rates decreased for only five (15.2 percent) of the performance measures compared with 2004. From a quality improvement perspective, the performance measures were a developing strength for **THC**, but the performance measures will require continued improvement in several areas already highlighted.

Validation of Performance Improvement Projects (PIPs)

THC's results for the Blood Lead Testing PIP are presented in Table N-3 and Table N-4. Table N-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. **THC** achieved a *Met* validation status with an overall score of 96 percent for its Blood Lead Testing PIP. This score was indicative of competent conduct and documentation for a PIP.

Table N-3—Overall PIP Scores *for* THC	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**96%**
Validation Status	***Met***

Table N-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table N-4—PIP Activity Scores *for* THC						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	4	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	9	0	0	0
IX.	Real Improvement Achieved	4	3	1	0	0
X.	Sustained Improvement Achieved	1	0	1	0	0
Totals for all Activities		**53**	**45**	**2**	**0**	**6**

For all 53 PIP elements evaluated, 45 were *Met*, 2 were *Partially Met*, zero were *Not Met*, and 6 were *NA*. The findings indicated that **THC** understood the PIP process and was able to conduct and produce valid PIPs. Of the 47 scored elements (i.e., 53 total elements minus the 6 that were *NA*), **THC** scored a *Met* on all but two, evidencing real improvement and achieving sustained improvement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **THC**'s composite CAHPS scores are shown in Table N-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table N-5—THC Detailed Results for CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	64.7%	68.8%	2.49	2.55	★★
Getting Care Quickly	43.1%	44.6%	2.09	2.14	★★
How Well Doctors Communicate	57.9%	56.1%	2.39	2.37	★
Courteous and Helpful Office Staff	62.0%	64.4%	2.45	2.51	★★
Customer Service	NA	71.2%	NA	2.64	★★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that three of the four top box percentages reported in 2004 improved for 2005 (Customer Service did not have a sufficient number of respondents for 2004). In 2005, Customer Service showed the highest results using three frames of reference. Both its top box percentage and its three-point mean were the highest of the four composite scores. Plus, Customer Service was the only composite measure to score above the national Medicaid 75th percentile in 2005.

The How Well Doctors Communicate measure had below-average performance for 2005 from a national perspective. This finding suggests that **THC** give priority to this measure as an opportunity for improvement.

THC's detailed scores for the global ratings are presented in Table N-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table N-6—THC Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	55.2%	57.3%	2.36	2.41	★★
Rating of Specialist	60.5%	62.0%	2.46	2.48	★★
Rating of All Health Care	47.2%	48.0%	2.25	2.25	★
Rating of Health Plan	42.1%	51.0%	2.14	2.30	★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that the rates for all four measures increased compared with 2004. Yet, the overall performance level was about average for three of these measures and below average for the fourth measure from a national perspective. Combined, these results suggested that credit should be given for the increases, but the areas still represented opportunities for improvement, especially Rating of All Health Care, where **THC** scored below the 25th national percentile.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

THC's on-site review results showed considerable performance strengths, particularly in the areas of Administrative, Member, Quality Assurance/Utilization Review, and Fraud and Abuse. The results indicated that **THC** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; content and distribution of member materials; processes for handling grievances, appeals, and State fair hearing requests; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; and fraud and abuse policies and procedures, risk management methodology, claims auditing processes and utilization trending procedures. It was noteworthy that **THC** was one of three MHPs to demonstrate compliance with all standards in the area of Fraud and Abuse. The plan had two opportunities for improvement to achieve full compliance with the requirements of the Medicaid managed care contract. **THC** submitted the required corrective action plan to MDCH to address the opportunities for improvement in the core areas of Provider and MIS/Data Reporting/Claims Processing. **THC**'s action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that the plan:

- Amend the Oakland County Community Mental Health Services Program agreement to address data and reporting requirements and quality improvement coordination. The June 2005 on-site review report stated that **THC** amended this agreement on May 27, 2004, to address all the categories of this criterion. Oakland County is no longer a part of the **THC** Medicaid service area.
- Pay all claims within the Medicaid-required time frames and provide a detailed plan for bringing the plan's claims payments into compliance. This was the third consecutive *Fail* score for this criterion. The June 2005 on-site visit found that **THC** had met the performance standards for claims processing.

Performance Measures

It was recommended in FY 2005 that **THC** reevaluate all well-child visit interventions to determine which interventions brought about performance improvement. **THC**'s 2006 QI evaluation described interventions designed to improve these rates and stated that there had been substantial improvements over time.

Another recommendation made in FY 2005 was that efforts to improve Postpartum Care rates be reevaluated and strengthened. **THC**'s 2006 QI evaluation described interventions designed to improve these rates and stated that there had been substantial improvements over time. The 2005 rate for Postpartum Care remained below the NCQA national 50th percentile.

Finally, it was recommended in FY 2005 that **THC** consider exploring barriers to accessing care and implementing targeted interventions, which may improve access rates and, subsequently, other dimensions of care. Improving access to care was a primary objective stated in **THC**'s 2006 QI Work Plan.

Performance Improvement Projects (PIPs)

THC showed opportunities for improvement in its 2004–2005 Childhood Immunization PIP in Activity 2, Element 1, "State the study question;" Activity 2, Element 3, "Study question answerable;" Activity 3, Element 1, "Clearly defined study indicators;" Activity 3, Element 3, "Allow study for study question to be answered;" Activity 6, Element 11, "Data Completeness;" and Activity 8, Element 7, "Identify statistical difference between measurement periods." **THC** showed improvement in all six areas in its 2005–2006 Blood Lead Testing PIP. The study question was provided and answerable, the indicators were clearly defined and measurable, the indicators allowed for the question to be answered, the data completeness percentage was provided, and statistical significance testing was performed between measurement periods.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

One of **THC**'s CAHPS global ratings reported in 2005, the overall Rating of Specialist, fell between the NCQA national 50th and 75th percentiles, and another, the overall Rating of All Health Care, fell between the 25th and 50th percentiles. The other two global ratings and all the composite scores reported were below the 25th percentile. It was recommended that **THC** consider identifying the key drivers of the CAHPS measures receiving low scores, and designing and implementing targeted QI activities. This was not addressed in **THC**'s QI evaluation or work plan.

Conclusions and Recommendations

The results from **THC** suggested more plausible opportunities for improvement than they did strengths that might be generalized for others to share. For example, from the annual compliance review, only one of the six categories (i.e., MIS/Data Reporting/Claims Processing) scored higher than 64.0 percent, although that category scored 100 percent. In summary, only 22 of 36 elements (61.1 percent) were passed. The category results presented a high-priority opportunity for improvement for **THC**.

Within the performance measures, the rates for eight measures were at or above the 75th national Medicaid percentiles. These rates suggested areas of strength within **THC**. Alternatively, the 12 measures with rates that were below the 25th national Medicaid percentile presented opportunities for improvement for **THC**.

PIPs were shown to be an area of strength. The only two opportunities for improvement were in the areas for evidencing real achievement, where **THC** did not meet the requirements of one of the four applicable elements within the activity, and sustained improvement.

A comparative assessment of the CAHPS composite scores showed that the lowest score was for How Well Doctors Communicate when compared with national results. For the global measures, Rating of All Health Care was the most likely priority for improvement from a national perspective.

Except for performance measures under the Timeliness domain, all of the averages for **THC** were below the statewide averages. However, the averages for PIPs and CAHPS were similar to the statewide averages. These findings indicated that **THC** had a QI program that met some of the State's expectations. The plan should prioritize and focus resources on areas of improvement.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table O-1 shows each of the six administrative standards, the number of standards passed, the total number of standards (e.g., under the column labeled Number, 4/4 represents four out of a total of four standards passed), the percentage of standards passed, and the statewide averages for each of the standards. As noted in Section 2 of the main report, HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

Table O-1—UPP Detailed Scores for the Annual Compliance Review Measures

Compliance Review Measures	Passed Measures for UPP		State Average
	Number	Percent	
Administrative	4/4	100%	97.0%
Provider	4/4	100%	88.5%
Member	3/3	100%	93.9%
Quality/Utilization	5/5	100%	82.8%
MIS/Data Reporting/Claims Processing	2/5	40.0%	85.5%
Fraud and Abuse	8/11	72.7%	86.1%

The table shows that **UPP** achieved perfect scores for four of the six annual compliance review measure categories: Administrative, Provider, Member, and Quality/Utilization. These categories and the elements contained within each were recognized strengths for **UPP**.

In contrast, the rate for the Fraud and Abuse category presented a significant opportunity for improvement when compared with the statewide average. Further, **UPP** passed 8 of the 11 elements in Fraud and Abuse, suggesting ample opportunity for improvement within the Fraud and Abuse category.

The lowest relative and absolute performance for the six categories was for MIS/Data Reporting/Claims Processing. For MIS/Data Reporting/Claims Processing, **UPP** only passed two of the five elements within the category. This category represented a high-priority opportunity for improvement for **UPP**.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures. The results of this assessment are presented in Table O-2. The table shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

Table O-2—UPP Scores for Performance Measures

Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Childhood Immunization Combo 2	68.9%	72.1%	★★★
Adolescent Immunization Combo 2	39.2%	62.7%	★★★
Appropriate Treatment for Children With URI	79.0%	82.1%	★★
Breast Cancer Screening	72.6%	67.8%	★★★
Cervical Cancer Screening	74.9%	73.0%	★★★
Controlling High Blood Pressure	65.1%	73.0%	★★★
Chlamydia Screening, 16–20 Years	45.9%	43.2%	★★
Chlamydia Screening, 21–26 Years	41.4%	42.0%	★★
Chlamydia Screening (Combined)	43.9%	42.7%	★★
Diabetes Care—HbA1c Testing	90.5%	91.6%	★★★
Diabetes Care—Poor HbA1c Control*	26.0%	23.9%	★★★
Diabetes Care—Eye Exam	62.3%	60.3%	★★★
Diabetes Care—LDL-C Screen	89.5%	92.3%	★★★
Diabetes Care—LDL-C Level <130	56.0%	61.7%	★★★
Diabetes Care—LDL-C Level <100	31.4%	37.1%	★★★
Diabetes Care—Nephropathy	52.8%	64.0%	★★★
Asthma 5–9 Years	81.5%	66.0%	★★
Asthma 10–17 Years	74.3%	70.6%	★★★
Asthma 18–56 Years	79.5%	69.1%	★★
Asthma Combined Rate	78.4%	68.8%	★★

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table O-2—UPP Scores for Performance Measures			
Performance Measures	Rate for 2004	Rate for 2005	Performance Level for 2005
Medical Assistance With Smoking Cessation	65.8%	66.2%	★★
Well-Child 1st 15 Months, 0 Visits*	0.9%	0.9%**	★★★
Well-Child 1st 15 Months, 6+ Visits	52.0%	52.0%**	★★
Well-Child 3rd–6th Years of Life	56.2%	58.6%	★★
Adolescent Well-Care Visits	37.2%	37.2%**	★★
Timeliness of Prenatal Care	88.0%	85.2%	★★★
Postpartum Care	57.7%	53.5%	★★
Children's Access 12–24 Months	97.4%	97.7%	★★★
Children's Access 25 Months–6 Years	88.0%	85.2%	★★
Children's Access 7–11 Years	84.2%	84.0%	★★
Adolescents' Access 12–19 Years	87.2%	85.0%	★★
Adults' Access 20–44 Years	86.3%	83.7%	★★★
Adults' Access 45–64 Years	90.7%	88.4%	★★★

* Lower rates are better for this measure.

** A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table O-2 shows that **UPP**'s rates were above the national Medicaid HEDIS 2004 75th percentile for 18 performance measures. These measures represented more than half of the selected measures for review. These 18 measures with above-average rates represented separate areas of strength for **UPP** , but they also suggested an overall strength in the program.

The table also shows that rates for 15 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. None of the rates was below the national Medicaid HEDIS 2004 25th percentile, further evidencing the performance measures, in general, as an area of relative strength for **UPP**.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. For 2005, three measures were rotated from 2004 and, therefore, were not included in this evaluation. Rates improved for only 14 of the 30 (46.7 percent) nonrotated performance measures compared with rates reported in 2004. The rate for Adolescent Immunization Combo 2 increased from 39.2 percent to 62.7 percent between the 2004 and 2005 assessments, indicating a substantive improvement.

Rates declined for 16 (53.3 percent) of the nonrotated performance measures compared with 2004. Although none of the 2005 rates was below the 25th national Medicaid percentile, the finding that more than half of the rates declined between 2004 and 2005 suggested that several opportunities for

improvement existed within the performance measures to prevent the above-average performance from degrading over time. For example, all of the rates related to asthma medication declined, some by substantively large amounts (e.g., the rate for Asthma 5–9 Years decreased from 81.5 percent to 66.0 percent between 2004 and 2005 and was rated as average from a national perspective). Clearly, although overall performance was above the national average, important opportunities for improvement exist for the **UPP** to remain a relatively high-performing MHP.

Validation of Performance Improvement Projects (PIPs)

UPP's results for the Blood Lead Testing PIP are presented in Table O-3 and Table O-4. Table O-3 shows that 100 percent of the critical elements of the PIP were determined to be *Met*. **UPP** achieved a *Met* validation status with an overall score of 95 percent for its Blood Lead Testing PIP. This score was indicative of competent conduct and documentation for a PIP.

Table O-3—Overall PIP Scores *for* UPP	
Percentage Score of Critical Elements *Met*	**100%**
Percentage Score of Evaluation Elements *Met*	**95%**
Validation Status	***Met***

Table O-4 presents the scoring for each of the activities in a PIP. The table shows the number of elements within each activity and, of those, the number that were *Met, Partially Met, Not Met,* or scored as *NA*.

Table O-4—PIP Activity Scores *for* UPP						
	Review Activity	Number of Evaluation Elements	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*
I.	Appropriate Study Topic	6	6	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1
IV.	Correctly Identified Study Population	3	3	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0
VI.	Accurate/Complete Data Collection	11	6	0	0	5
VII.	Appropriate Improvement Strategies	4	2	0	0	2
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	1	0
IX.	Real Improvement Achieved	4	3	0	1	0
X.	Sustained Improvement Achieved	1	0	0	0	1
Totals for all Activities		**53**	**42**	**0**	**2**	**9**

For all 53 PIP elements evaluated, 42 were *Met*, zero were *Partially Met*, 2 were *Not Met*, and 9 were *NA*. The findings indicated that **UPP** understood the PIP process and was able to conduct and produce valid PIPs. Of the 44 scored elements (i.e., 53 total elements minus the 9 that were *NA*), **UPP** scored a *Met* on all but 2.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **UPP**'s composite CAHPS scores are shown in Table O-5. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

Table O-5—UPP Detailed Results for the CAHPS 3.0H Composite Scores

CAHPS Measures	Top Box Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Getting Needed Care	70.6%	74.4%	2.59	2.65	★★
Getting Care Quickly	46.3%	48.1%	2.24	2.29	★★★
How Well Doctors Communicate	60.0%	60.2%	2.49	2.48	★★
Courteous and Helpful Office Staff	67.2%	70.4%	2.59	2.62	★★★
Customer Service	60.8%	68.1%	2.45	2.60	★★★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that all five of the top box composite score percentages reported in 2004 improved for 2005. For 2005, the performance level was above average for three measures (i.e., Getting Care Quickly, Courteous and Helpful Office Staff, and Customer Service) from a national perspective. Together, these findings strongly suggested that the composite scores were an overall strength for **UPP**.

UPP's detailed scores for the global ratings are presented in Table O-6. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

Table O-6—UPP Detailed Scores for the CAHPS 3.0H Global Ratings

CAHPS Measures	Top Satisfaction Percentage		Three-Point Mean		Performance Level for 2005
	2004	2005	2004	2005	
Rating of Personal Doctor	58.9%	58.5%	2.44	2.47	★★
Rating of Specialist	57.6%	52.0%	2.44	2.30	★
Rating of All Health Care	51.2%	50.1%	2.32	2.32	★★
Rating of Health Plan	38.3%	42.6%	2.06	2.17	★

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that three of the four the rates declined compared with 2004. Only Rating of Health Plan increased, but its overall performance, as well as that of Rating of Specialist, was still below the 25th national Medicaid percentile. None of the rates reached the 75th national Medicaid percentile. Combined, these results represented opportunities for improvement for all of the global rating measures.

Assessment of MHP Follow-up on Prior Recommendations

Annual Compliance Reviews

UPP's FY 2005 on-site review results showed both performance strengths and opportunities for improvement to achieve full compliance with the requirements of the Medicaid managed care contract. The plan's strengths were in the core areas of Administrative, Quality Assurance/Utilization Review and MIS/Data Reporting/Claims Processing. The results indicated that **UPP** demonstrated compliance with criteria related to the structure of the organization; composition, function, and activities of the governing body; practice guidelines; the QAPI program; access to care; the utilization management program; credentialing/recredentialing protocols; programs for individuals with special health care needs; and information system requirements, financial and administrative reporting to MDCH, timeliness of payments, and management of enrollment data. **UPP** submitted the required corrective action plan to MDCH to address opportunities for improvement in the core areas of Provider, Member, and Fraud and Abuse. **UPP**'s action plan, deemed acceptable by MDCH in terms of scope, content, and established timeline, required that **UPP**:

- Submit the Trizetto TPA Management contract and UPP, Inc., Management Agreement to the DMB. **UPP** must develop and maintain a policy that demonstrates a process to submit any subcontracts and/or delegation agreements for administrative or management functions to the DMB and MDCH 21 days prior to the effective date of the agreement or contract. At the October 2004 on-site visit, it was noted that the Trizetto contract had not been continued and that **UPP** was currently identifying any subcontracts and/or delegation agreements for administrative or management functions.
- Inform members that **UPP** will provide assistance with completing forms and procedures for resolution of grievances and appeals from enrollees. The October 2004 on-site visit found that **UPP** had revised its member handbook and a policy regarding customer service staff to address this issue.
- Develop processes to use the information obtained when identifying under- and overutilization to locate potential fraud and abuse. The October 2004 on-site visit found that **UPP** had addressed this issue.
- Begin using or adapt the current processes/reports specified in the plan's process to detect fraud and abuse by providers. If fraud or abuse is noted, the plan's committee meeting minutes should reflect the discussion of the provider's issue(s) and any corrective action instituted. **UPP** should notify MDCH/PIS of any instance of provider fraud or abuse. The October 2004 on-site visit found that **UPP** had addressed this issue.
- Review the EPLS when verifying provider credentials during the credentialing/recredentialing process. This area was not mentioned in the October 2004 site review report.

Performance Measures

In FY 2005, it was recommended that **UPP** focus improvement efforts on well-child care visits for children and adolescents. Improvement efforts could be coupled with existing immunization performance efforts to maximize effective use of resources. **UPP**'s 2005 QI evaluation stated that improving these rates was included in its goal to improve the quality of services and health outcomes for members.

It was recommended in FY 2005 that **UPP** consider exploring intervention options for chlamydia screening, an area that offers an opportunity for improvement. **UPP**'s 2005 QI evaluation stated that improving these rates was included in its goal to improve the quality of services and health outcomes for members.

The rate reported in FY 2005 for Monitoring for Diabetic Nephropathy exceeded the 50th percentile, and it was recommended that this area be considered as a possible focus for improvement efforts. **UPP**'s 2005 QI evaluation stated that improving these rates was included in its goal to improve the quality of services and health outcomes for members.

Performance Improvement Projects (PIPs)

UPP showed opportunities for improvement in its 2004–2005 Childhood Immunization PIP in Activity 8, Element 7, "Identify statistical difference between measurement periods." **UPP** showed improvement in its 2005–2006 Blood Lead Testing PIP by performing statistical significance testing between measurement periods.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

UPP's composite score reported in 2005 for Getting Care Quickly fell between the NCQA national 75th and 90th percentiles. Two global ratings (Rating of Personal Doctor and Rating of Specialist) and two composite scores (How Well Doctors Communicate and Courteous and Helpful Office Staff) fell between the 50th and 75th percentiles. All other measures fell between the 25th to 50th percentiles except for the overall Rating of Health Plan, which fell below the 25th percentile. These CAHPS results suggested that members' experiences accessing and receiving care may not be as consistently positive as the high quality of care identified in the HEDIS findings. It was recommended that **UPP** consider further examining the key drivers of the CAHPS measures that fell below the 50th percentile. **UPP**'s 2005 QI evaluation stated that improving these rates was included in its goal to improve member satisfaction.

Conclusions and Recommendations

The current review of **UPP** showed both strengths and opportunities for improvement. The results from selected annual compliance review measures, performance measures, and CAHPS measures, plus the PIP scores, represented definite areas of strength for **UPP**, some at or approaching best practices. MDCH might want to consider various methods to generalize the policies and practices at **UPP** that seemed responsible for the exemplary performance in these areas.

From the assessment of the compliance review measures, **UPP** should make as a high priority implementing policies and procedures to rectify the results of Provider and MIS/Data Reporting/Claims Processing. Further, the results for the Fraud and Abuse category suggest that quality improvement efforts for the not-passed elements are needed.

From the assessment of the performance measures, 18 rates were above the national Medicaid HEDIS 2004 75th percentile. These measures represented relative areas of strength for **UPP**. Not a single rate was below the 25th national Medicaid percentile. Nonetheless, rates for 16 measures declined, but not below the 25th national Medicaid percentile levels.

PIPs were shown to be an area of strength. The only two opportunities for improvement were in the areas for evidencing real achievement, where **UPP** did not meet the requirements of one of the nine elements in data analysis and interpretation and one of the four elements within evidencing real improvement achieved.

The assessment of the CAHPS scores suggested somewhat above-average scores for the composite scores and below-average scores for the global ratings, both relative to the national Medicaid percentiles. The issues reflected by the declining or nationally low global rating measures should be high-priority opportunities for improvement for **UPP**.

For the categories of Quality, Timeliness, and Access, **UPP**'s scores showed mixed results, with six categories above the statewide averages and five below. The results indicated overall average performance. All of the categories under Access were above the statewide averages, indicating a relative strength in this area. Performance measures were also a strength, with higher averages than the statewide averages in every domain. These findings indicated that **UPP** had an established QI program that met most of the State's expectations for access to care, structure and operations, and quality measurement and improvement.